



University of Chester

**This work has been submitted to ChesterRep – the University of Chester’s
online research repository**

<http://chesterrep.openrepository.com>

Author(s): Frances Mann; Simon Alford; Miranda Thurston

Title: Warrington Community Alcohol Service: Final evaluation report

Date: November 2007

Originally published in:

Example citation: Mann, F., Alford, S., & Thurston, M. (2007). *Warrington Community Alcohol Service: Final evaluation report*. Chester: University of Chester

Version of item: Published version

Available at: <http://hdl.handle.net/10034/15725>

Warrington Community Alcohol Service

Final Evaluation Report

Frances Mann

Simon Alford

Miranda Thurston

November 2007

Acknowledgements

This evaluation has involved the participation of several groups whose contributions have been important in examining the processes and outcomes for the Warrington Community Alcohol Service. The evaluation team would like to thank the following people for their cooperation:

- Wendy Kay, Centre Manager, ADS, Warrington;
- service users and staff from ADS, Warrington;
- staff from referring agencies: mental health services, the police, the probation service and secondary care services.

This evaluation was commissioned and funded by Warrington Primary Care Trust.

Contents

Acknowledgements	i
Contents	ii
Tables	v
Figures	vi
Summary	vii
Chapter 1 Background	1
1.1 Alcohol misuse in the UK	1
1.2 Policy and guidance	2
1.3 Alcohol treatment	2
1.4 Warrington's Alcohol Harm Reduction Strategy	4
Chapter 2 Warrington Community Alcohol Service	5
2.1 Introduction	5
2.2 Warrington Community Alcohol Service	5
2.3 The commissioned organisation: Alcohol and Drug Services	5
2.4 Monitoring and evaluation	9
2.4.1 Evaluation framework	9
2.4.2 Routinely collected quantitative data on service activity	10
2.4.3 Quantitative outcome measures	11
2.4.4 Qualitative interviews	11
2.4.5 Recruitment process for interviews	12
Chapter 3 Service activity data June 2006 – August 2007	14
3.1 Introduction	14
3.2 Service user characteristics	14
3.3 Numbers of referrals	15
3.4 Referral source	17
3.5 Initial and comprehensive assessments	19
3.6 Treatment activity	21
3.7 Response times	24
3.8 Discharge rates	25
Chapter 4 Outcomes	27
4.1 Introduction	27

4.2	Outcomes for service users: Christo scores	27
4.3	Alcohol consumption	28
4.4	Services users' views of the impact of the Service	29
4.4.1	Mental health	30
4.4.2	Physical health	31
4.4.3	Improving social and family functioning	31
4.4.4	Relapse prevention	32
Chapter 5 Service processes		33
5.1	Introduction	33
5.2	Referral processes	33
5.3	Accessing treatment: hazardous and harmful drinkers	33
5.4	Engagement with the Service	34
5.5	Response times and service flexibility	35
5.6	Care planning	36
5.7	Collaboration and cooperation	38
5.7.1	Mental health services	38
5.7.2	Crime and disorder	39
5.7.3	Hospital services	40
5.8	Future service development	41
5.9	Scope of the Service	42
Chapter 6 Discussion		44
6.1	Introduction	44
6.2	Data management	44
6.3	Community Alcohol Service achievements	45
6.4	Key processes	45
6.5	Issues for consideration	47
6.6	Implications for future strategy and practice	49
References		51
Appendices		
Appendix 1	Key performance indicators	53
Appendix 2	Christo screening tool	54
Appendix 3	Service user interview schedule	55
Appendix 4	ADS staff focus group schedule	56

Appendix 5	External agency staff interview schedule	57
Appendix 6	Participant letter of invitation	58
Appendix 7	Participant information sheet and consent form	59
Appendix 8	Monthly activity report template	60

Tables

		Page
Table 3.2.1	Ethnicity of individuals referred to ADS	15
Table 3.3.1	Referral activity by sex	16
Table 3.4.1	Referral source by sex	18
Table 3.4.2	Referral source by age group	19
Table 3.6.1	Client activity by treatment modality	22
Table 3.6.2	Counselling sessions by age and sex	22
Table 3.6.3	Group work sessions by age and sex	22
Table 3.6.4	Acupuncture sessions by age and sex	23
Table 3.6.5	Community detoxification sessions by age and sex	23
Table 3.7.1	Number of days between referral and assessment	24
Table 3.7.2	Number of days between assessment and first intervention	25
Table 3.8.1	Total number of discharges by individual service users	26
Table 4.2.1	Mean (SD) Christo scores at baseline and follow up for males, females and combined	28
Table 4.3.1	Alcohol use at case review by sex	29
Table 4.3.2	Alcohol use at case review by age group	29

Figures

	Page
Figure 2.3.1 Service process	8
Figure 3.2.1 Age and sex of individuals accessing ADS	15
Figure 3.3.1 All ADS referrals by sex between June 2006 – Aug 2007	16
Figure 3.4.1 Referral source: June 2006 – August 2007	17
Figure 3.5.1 Initial assessments completed: setting	20
Figure 3.5.2 Comprehensive assessments completed: setting	20
Figure 3.5.3 Comprehensive assessment: completed and DNA	21
Figure 3.8.1 Cases discharged between June 2006 and August 2007	25
Figure 4.2.1 Baseline Christo scores	27

Summary

Background

In 2004, the Government published its *Alcohol Harm Reduction Strategy for England*, a national strategy to tackle alcohol-related harm. This document considered the extent to which increasing alcohol misuse and associated health-harming and anti-social behaviour impact on individuals, families and local communities.

The North West of England has higher estimates of alcohol consumption and higher rates of alcohol-related mortality than any other part of England. Within the North West, Warrington has a higher than average incidence of admissions for both alcohol-attributable and alcohol-specific conditions, particularly amongst its female population. Warrington's *Alcohol Harm Reduction Strategy* is built around four key themes: information, education and communication; improving treatment and care; protecting young people, and, combating alcohol-related crime and disorder. In 2005, as part of the action plan for the 'improving treatment and care' theme, Warrington Primary Care Trust commissioned a Community Alcohol Service delivered by ADS. In 2006, the Centre for Public Health Research at the University of Chester was commissioned to evaluate this Service.

Aims of the evaluation

The aims of the evaluation were to:

- analyse service activity between June 2006 and August 2007;
- explore service user experiences amongst those who had been referred;
- examine the outcomes for service users in relation to improving physical and mental health and social and family functioning, and reducing the harm to the individual and concerned others;
- explore service processes underpinning the delivery of the Community Alcohol Service.

Key findings

Service activity

- Two thirds of service users were male.
- Over half of all referrals were in the 30-49 year age category.
- The majority of referrals were categorised as 'self' or GP referrals.
- DNA rates for comprehensive assessment appointments averaged 48% over the 15 month period.

-
- The attendance rate at treatment sessions was 74%.
 - 68% of referrals were seen within seven days and 92% were seen within 14 days.
 - 78% of service users entered treatment within 14 days of assessment.

Service outcomes

- Analysis of Christo outcome evaluation test scores showed improvements for 85% of those service users (175) for whom baseline and follow-up scores were available.
- At case review, 72% of service users for whom data on alcohol consumption were available (269) reported being abstinent for at least the previous seven days.
- There was qualitative evidence of a positive impact on mental and physical well-being, with service users making specific reference to improvements in feelings of self-worth, confidence and ability to manage anxiety.
- Aftercare support and peer group work were highlighted as key factors in managing misuse issues. Group activities were also identified by service users as important in encouraging engagement in activities outside ADS.

Service processes

- Service users interviewed expressed high levels of satisfaction with the nature and level of support offered by the ADS team.
- Service users and referring agency staff expressed the view that ADS had been successful in engaging service users because of clear ground rules combined with a degree of flexibility and informality.
- The timeliness of the service response was highlighted by both service users and external agency staff as a contributing factor in harnessing and strengthening motivation to address misuse.
- Difficulties were experienced in securing the participation of all GP practices in the Warrington area.
- Joint working arrangements based on collaboration and cooperation between ADS and external agencies such as mental health, secondary care and crime and disorder services were evident in the interviews with staff.

Issues for consideration

The findings from the evaluation were used to identify a number of issues for further consideration. In particular, the following implications for future service development were identified:

- the potential value of intensifying efforts to promote knowledge and awareness of alcohol treatment issues amongst Tier 1 and 2 organisations and agencies in the locality;
- the development of a strategy, with the support of Warrington Primary Care Trust, to broaden the referral base to include the identification and treatment of hazardous and harmful drinkers;
- to consider the capacity of the service to respond to demand in a timely manner if the strategy to increase the Service's profile amongst GP practices is successful;
- the expansion of the scope of the service to address the needs of those individuals who misuse alcohol who are unable to access centre-based ADS services, for example, individuals with complex needs, vulnerable adults and women with childcare responsibilities;
- to review the adequacy of procedures regarding the collection and management of monitoring data to meet all reporting requirements, particularly in respect of output and outcome data.

Chapter 1

Background

1.1 Alcohol misuse in the UK

Alcohol consumption in the UK has been steadily rising and during the last two decades deaths from alcohol-defined conditions have virtually doubled (Office for National Statistics [ONS], 2006). Hospital episode statistics produced in 2006 showed that hospital admissions for selected alcohol-related diagnoses had also almost doubled since 1997 (Information Centre for Health and Social Care, 2006). Department of Health figures estimate that around half of both violent crimes and domestic violence incidents are linked to alcohol misuse (Department of Health [DH], 2004; DH, 2007).

The North West of England has higher estimates of alcohol consumption and higher rates of alcohol-related mortality than any other part of England (North West Public Health Observatory [NWPHO], 2006). A report published in August 2007 by the National Association of Public Health Observatories (APHO) contained the following key finding:

The poorest local authorities (those with the highest measures of multiple deprivation) also tend to have the highest recorded levels of health and social outcomes related to alcohol use: crime, anti-social behaviour orders, teenage conceptions, chronic liver disease, incapacity benefit claimant rates and unauthorised school absences. (APHO, 2007, p.14)

Within the North West, Warrington has a higher than average incidence of admissions for both alcohol-attributable and alcohol-specific conditions, particularly amongst its female population (NWPHO, 2006). In particular, the figures for hospital admissions for females with alcohol-related and alcohol specific conditions for 2005/06 show Warrington ranking in the highest quartile. Rankings for alcohol-related harm indicators (the local authority ranked as 1 indicating the lowest impact of alcohol and 354 the local authority with the highest impact) show Warrington ranked 345th for alcohol-related female admissions and 342nd for alcohol specific female admissions (NWPHO, 2006). In 2006, a health and lifestyle survey was carried out for Warrington Primary Care Trust (PCT), which showed a 6% rise in harmful alcohol consumption in the population compared with levels reported in 2001 (Warrington Primary Care Trust [PCT], 2007a). A report published by the APHO in August 2007 cites particularly high levels of binge drinking amongst males in the North West which, at 26%, are the second highest in England. This report also shows figures from the 2005 General Household Survey,

which put the levels of hazardous and harmful drinking in the North West (18%) as the highest in the country.

This chapter briefly reviews recent policy on alcohol harm reduction in order to provide a contextual background to the evaluation of the Community Alcohol Service commissioned by Warrington Primary Care Trust.

1.2 Policy and guidance

The widening recognition of alcohol misuse as a pervasive social problem has seen the development of cross-departmental, joint working approaches being advocated in policy documents. In 2004, the Government published its *Alcohol Harm Reduction Strategy for England*, a national strategy to tackle alcohol-related harm. This document considered the extent to which increasing alcohol misuse and associated health-harming and anti-social behaviour impact on individuals, families and local communities. In calculating the cost of alcohol misuse four key groups of alcohol-related harms were identified: health harms; crime and anti-social behaviour harms; loss of productivity and profitability, and harms to family and society (Prime Minister's Strategy Unit, 2004, p.17).

The national alcohol strategy guidance identifies a central role for a co-ordinated, partnership approach between relevant agencies and organisations in initiatives and interventions aimed at addressing alcohol misuse. A follow-up document, *Safe. Sensible. Social: The next steps in the National Alcohol Strategy* (DH, 2007) emphasises the importance of local alcohol strategies, co-ordinated by local partnerships, in the continued task of reducing alcohol-related harm in England. The document states that from 2008, in addition to the use of Local Area Agreements to formalise and strengthen each local alcohol strategy, all local Crime and Disorder Reduction Partnerships (CDRPs) would be required to include alcohol-related disorder and misuse in their strategies.

1.3 Alcohol treatment

The publication of the national *Alcohol Harm Reduction Strategy* was followed by the development of several guidance documents to support and strengthen local approaches to commissioning and delivering alcohol treatment services. These include:

-
- models of care for alcohol misusers (MoCAM) (DH, 2006a);
 - alcohol misuse interventions: guidance on developing a local programme of improvement (DH, 2005b);
 - Alcohol Needs Assessment Research Project (ANARP) (DH, 2005b);
 - review of the effectiveness of treatment for alcohol problems (DH, 2006b).

The key aim of these publications is to provide evidence-based guidance on best practice for alcohol treatment. All documents highlight the need for comprehensive, integrated alcohol treatment systems in the delivery of local needs-led alcohol services. In addition to placing their emphasis on the benefits to individuals and communities, they also highlight the economic argument for providing effective alcohol treatment services. This is illustrated in the following quotation from the Chief Medical Officer, Sir Liam Donaldson:

Recent studies suggest that alcohol treatment has both short and long-term economic benefits. The Review (of the effectiveness of treatment for alcohol problems) suggests that provision of alcohol treatment to 10% of the dependent drinking population within the UK would reduce public sector resource costs by between £109 million and £156 million each year.
(DH, 2006b, p.5)

The MoCAM document (DH, 2006a) identifies four categories of people who misuse alcohol whose needs require tailored treatment and intervention. These are hazardous, harmful, moderately dependent and severely dependent drinkers. The framework for commissioners and providers charged with the delivery of alcohol treatment and intervention services is detailed in this document. This four-tiered framework ‘maps’ the nature and level of treatment modalities aimed at providing a range of responses to alcohol misuse across all four categories. It provides an overview of opportunities for assessment, referral and intervention through indicating, but not prescribing, the ‘settings’ for the delivery of these assessments and interventions. Although the tiers relate to treatment modalities rather than agencies themselves, Tier 1 and Tier 2 interventions are more commonly delivered in non-alcohol specialist agency settings, such as GP surgeries. Tier 3 of the framework refers to ‘community-based specialised alcohol-misuse assessment and alcohol treatment that is care co-ordinated and care planned’ (DH, 2006a, p.22). Thus, it is recommended that the work of a local community alcohol service will also involve the provision of support, training, and, in some cases, resources to agencies delivering provision at Tiers 1, 2 and 4 (DH, 2006a, p.22).

1.4 Warrington's Alcohol Harm Reduction Strategy

Warrington's *Alcohol Harm Reduction Strategy* is built around four key themes: information, education and communication; improving treatment and care; protecting young people, and, combating alcohol-related crime and disorder. Each of these themes of the Strategy has an action plan that sets out defined outcomes against which progress is measured (Warrington Local Strategic Partnership [LSP], 2005). In 2005, as part of the 'improving treatment and care' action plan, Warrington PCT commissioned a Community Alcohol Service. Chapter 2 describes the Community Alcohol Service, the focus of this evaluation report.

Chapter 2

Warrington Community Alcohol Service

2.1 Introduction

This chapter provides the relevant background to the evaluation. First, it provides a service description of the Community Alcohol Service commissioned by the PCT and provided by the Alcohol and Drugs Service (ADS). Second, it describes the aims, objectives and performance indicators that were defined for the Service and which were used as a framework for the evaluation. Third, it outlines the methodology for the evaluation.

2.2 Warrington Community Alcohol Service

The primary aim of the Community Alcohol Service is to address the needs of Warrington's alcohol misusing population, as a Tier 3 provider, as well as through collaboration with agencies providing Tiers 1, 2 and 4 services. The service specification for the Community Alcohol Service identifies thirteen key performance measures (see Appendix 1). These indicators relate to key aspects of performance in relation to referral, treatment, and response, and provide a framework for the reporting of activities and outputs.

The outcomes for the service relate directly to service user experience and health impact. In terms of the latter, the following outcomes have specifically been identified:

- improving physical and mental health;
- improving social and family functioning;
- reducing the harm to the individual and concerned others;
- reducing the rates of mortality and hospital/GP attendances.

(Warrington PCT, 2005)

2.3 The commissioned organisation: Alcohol and Drug Services

In March 2006, Warrington PCT commissioned ADS as the new provider of a structured community-based alcohol service. ADS, established in 1973, provides alcohol and drug services across the four Tiers of both Models of Care for Alcohol Misusers (MoCAM) and Models of Care for Drug Misusers (MoCDM) at thirteen locations in the North West. The organisation operates a 'stepped care treatment system' which aims to ensure 'that clients receive the least intrusive, most cost

effective interventions matched to indicated need' (ADS, 2005, p.18). The ADS Project Proposal emphasises the organisation's commitment to partnership work between agencies from Tiers 1 – 3 in the development of an effective integrated care pathway for people who misuse alcohol in Warrington.

In June 2006, ADS commenced delivering Warrington's Community Alcohol Service from premises in Warrington town centre. The Service focused on:

- screening, triage assessment and brief intervention for hazardous and harmful drinkers (Tiers 1 – 3);
- triage, comprehensive assessment, counselling and care planning for dependent drinkers (Tier 3);
- assessment and facilitation of community detoxification (Tier 3);
- aftercare support, in the form of structured day care and support (Tier 3);
- facilitating access to in-patient detoxification and residential rehabilitation services (Tier 4).

The Service is staffed by a full-time manager, one full-time administrator, two full-time centre-based project workers, one full and one part-time primary care-based project workers and one community detoxification nurse. In addition, the PCT has recently commissioned a pilot project consisting of a part-time ADS volunteer trainer based at Warrington Hospital to co-ordinate the work of twenty hospital-based volunteers working to befriend dependent drinkers admitted into the hospital.

The services delivered from the organisation's premises in Warrington town centre are aimed, predominantly, at meeting the needs of dependent drinkers. Following the referral of a dependent drinker to the Service, an initial assessment will take place. If the service user is suitable for, and in agreement with, a home detoxification the community nurse will arrange for a GP prescription of appropriate medication in order for the patient to undertake a nurse-supervised home treatment.

Where a home detoxification is not the appropriate option, the individual will be assessed by a project worker, and a care plan agreed. The care plan, incorporating a reduction programme, identifies goals and targets, the ultimate aim of which is a state of abstinence. The first stage of the care plan consists of approximately six one-to-one structured counselling sessions. Sessions are based around The *Stages of Change* model (Prochaska, Diclemente, & Norcross, 1992). This approach aims to ensure that

the chosen care plan corresponds with the individual's stage of awareness and motivation regarding addressing their alcohol dependency.

Participation in support groups is open to all service users, although involvement is more commonly scheduled post-counselling. Acupuncture sessions are also open to all service users.

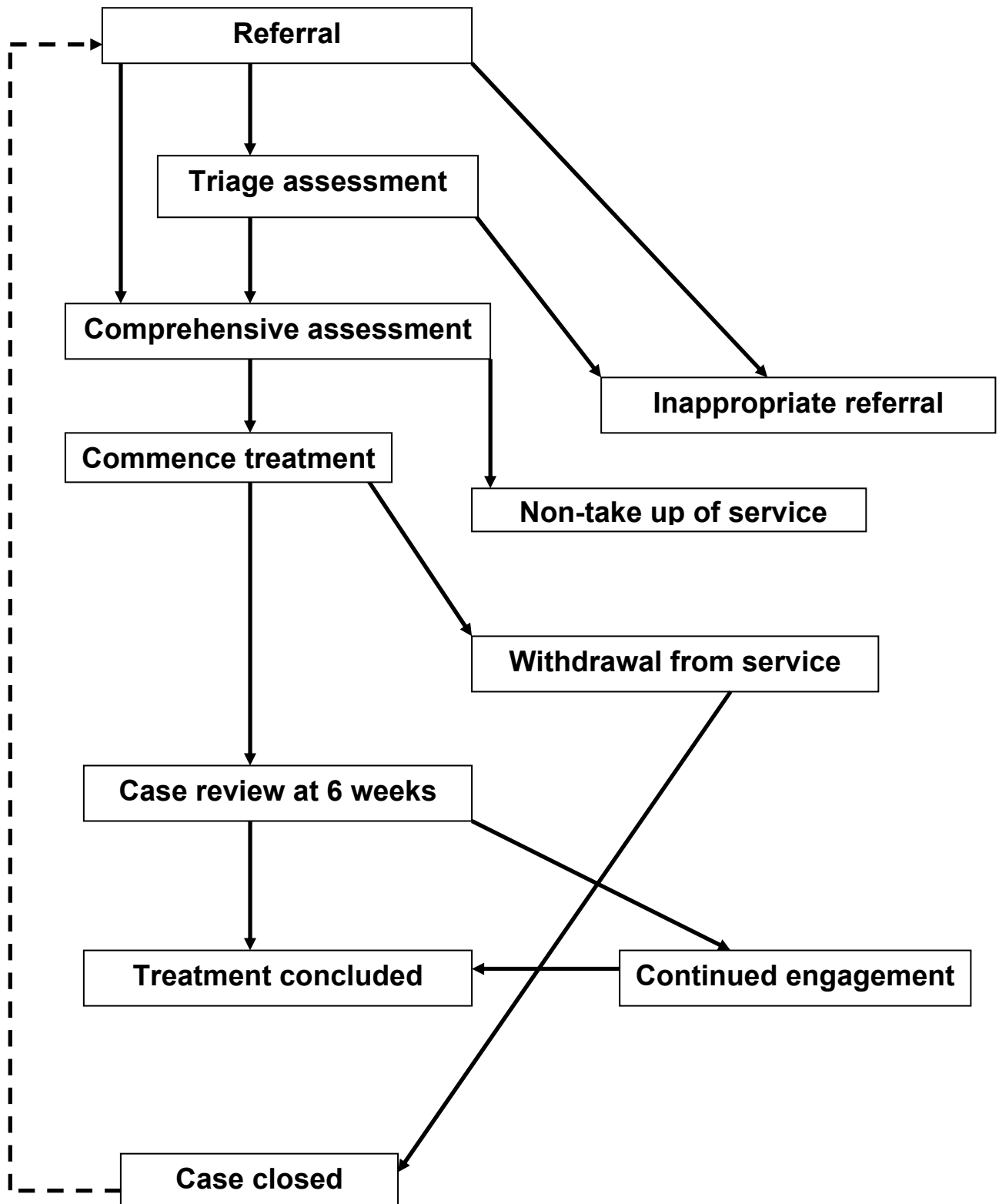
The Service also works with hazardous and harmful drinkers. The National Treatment Agency's (NTA) *Review of the effectiveness of alcohol treatments* described this category thus:

People drinking hazardously will not usually be seeking treatment for an alcohol problem although some may realise their drinking is putting them at risk ... the harmful drinking category applies to people drinking over medically recommended levels, probably at somewhat higher levels than in hazardous drinking ... they will show clear evidence of alcohol-related problems but often without this having resulted in their seeking treatment. (DH, 2006b, p. 20)

Project workers, working with 11 of the 29 local GP practices, deliver services for this group. Following GP referral, a worker will assess the individual's alcohol use using the AUDIT screening tool. Where appropriate, a dependent drinker will be referred on to a centre-based worker either for community detoxification or the dependent drinkers service (outlined above). If identified as a hazardous or harmful drinker a primary care-based worker will then deliver brief intervention sessions at the individual's GP surgery. Often centred on a 'motivational interviewing' approach, a brief intervention session will aim to raise individuals' awareness of the harmful effects of their behaviour. The *Stages of Change* model (Prochaska et al., 1992) also informs the selection of an individualised approach to the brief intervention. For patients who are at the *pre-contemplation* stage of the cycle, the practitioner will commonly focus the session on achieving a change in the patient's attitude to, and understanding of, the negative effects of his/her drinking behaviour. A session with a patient at the *preparation* stage will often involve discussion and consideration of strategies for achieving change. The number of sessions can range from one to a maximum of six. Patients are encouraged, where appropriate, to access all activities available at the town centre premises.

Figure 2.3.1 illustrates the service process from initial referral through to exit.

Figure 2.3.1 Service process



2.4 Monitoring and evaluation

The need for robust performance monitoring and evaluation is highlighted in government guidance (DH, 2006a). This identifies the need for both quantitative and qualitative data collection and analysis in order to be able to review service performance comprehensively in terms of inputs, outputs and outcomes. In 2006, the University of Chester's Centre for Public Health Research (CPHR) was commissioned by Warrington PCT to provide advice and support to aid the development and implementation of systems for the monitoring and evaluation of the services delivered by ADS, as provider of the commissioned Community Alcohol Service. In addition to the production of a final evaluation report, a principle function of the CPHR's involvement has been to assess the capability of the service provider's data collection and management systems to meet the specific monitoring and evaluation needs of Warrington PCT.

2.4.1 Evaluation framework

The evaluation framework developed by the CPHR (Mann & Thurston, 2007) was based on a formative and summative approach to the monitoring and evaluation of the Community Alcohol Service delivered by ADS. This outlined a three stage strategy for developing and advising on the implementation of systems, whilst also reviewing both processes and outcomes:

- Stage One: agreement of activity indicators and identification of appropriate systems to meet monitoring and evaluation needs;
- Stage Two: assessment of efficacy and appropriateness of systems for data collection and analysis, together with analysis of monthly output/activity reports, reported on in the Interim Report (Mann & Thurston, 2007);
- Stage Three: summative evaluation involving analysis of quantitative and qualitative data to evaluate project processes and outcomes.

During Stages One and Two, the team responsible for delivering technical support services to organisations using the RESULT system used by ADS to record service activity discontinued their services. Whilst this did not affect the continued use of the RESULT system it prevented the programme modifications suggested by the CPHR from being carried out.

In January 2007, an interim report was produced. The purpose of this was, firstly, to document progress on the implementation of a monitoring and evaluation strategy for

the Community Alcohol Service, and, secondly, to present an analysis of service activity for the first seven months of service delivery from June to December 2006. The report contained an analysis of available data regarding care and collaboration; care management and co-ordination; referral pathways; and, timescales for response. The main issues identified in the report were the inability of the RESULT system to meet all the activity reporting requirements as well as incomplete data being recorded in relation to service user outcomes. The primary recommendation was that if the service was to be able to meet the PCT's performance management requirements, then a new system provider would need to be commissioned. Furthermore, this system would need to incorporate additional elements in order to ensure conformity with the PCT requirements.

Three different approaches to data collection were employed during Stage Three of the evaluation:

- interrogation of routinely collected quantitative data on service activity;
- analysis of quantitative data relating to service user outcomes;
- qualitative interviews with service users, ADS staff and workers from external agencies who had referred clients to the service or who had been involved in the development of joint working initiatives.

2.4.2 Routinely collected quantitative data on service activity

ADS employ the RESULT (**R**outine **E**valuation of the **S**ubstance **U**se **L**adder of **T**reatments) system for the management of their data. This is a system that was developed by the Leeds Addiction Unit specifically to manage data relating to treatment activity, outcome and cost effectiveness. A function of this system is to supply data to comply with the requirements of the National Treatment Agency's National Drug Treatment Monitoring System (NDTMS). To ensure accurate and complete reporting the RESULT system operates a 'compulsory entry' field requirement for entering the necessary NDTMS data.

The RESULT system was interrogated in order to describe service activity for the analysis period in relation to the following:

- referrals;
- service response times;
- treatment modalities;
- discharge.

Data held on the system was also used to provide a description of service users in relation to age, sex and ethnicity.

2.4.3 Quantitative outcome measures

The Christo Inventory for Substance Misuse Services (CISS) is a validated tool employed by ADS to aid their treatment outcome monitoring and evaluation. The Christo is identified in Department of Health guidance as one of the four most commonly used alcohol treatment outcome measures (DH 2006b, p.77). It is described as being suitable for completion either face-to-face or from client assessment notes. It consists of a ten-item questionnaire, with questions that relate to substance misuse, physical and mental health, and social functioning (Christo Research Systems, 2000). Christo scores were recorded at baseline and case review stages in order to measure progress. Depending on the service user's response to each question a score is allocated: 0 – no problem; 1 – moderate problem; 2 – severe problem (see Appendix 2). Comparison of baseline and follow-up scores provided information on each service user's progress, with an overall decrease in score indicating an improvement. For the purpose of this evaluation, the Christo score was viewed as contributing information on outcomes in relation to improving physical and mental health, improving social and family functioning and, reducing the harm to the individual and concerned others.

In addition to the Christo scores, alcohol consumption was recorded at case review (normally scheduled to take place after six counselling sessions). The specific indicator used was the number of service users abstaining at this review stage. Abstention was defined in terms of the service user not having consumed alcohol in the seven days prior to case review.

All analysis of quantitative data was carried out using SPSS and Excel.

2.4.4 Qualitative interviews

Interviews were conducted with ADS service users, ADS staff, staff from external agencies who had made referrals during the 15 month period and individuals who had been involved in the development of joint working initiatives with ADS. These interviews aimed to explore the views and experiences of service users and others with whom ADS had worked. Interview schedules (see Appendices 3, 4 and 5) were designed to enable and encourage discussion of issues pertinent to specific

stakeholder experiences. All schedules aimed to generate evidence about both service processes and service user outcomes for those who had accessed the Warrington Community Alcohol Service.

Service users were asked about the impact of their engagement with ADS in relation to the following issues: alcohol consumption; physical and mental well-being; their day-to-day-life and the life of their family and friends. Although the interview schedule aimed to avoid any unnecessary intrusion into personal issues, many service users volunteered such information. Due to the difficulties of accessing service users whose contact with ADS was transient or erratic within the timescales of the project, the sample consisted of active service users only.

2.4.5 Recruitment process for interviews

Case workers at ADS were given envelopes for distribution to service users which contained: a letter inviting participation in the evaluation and a participant information sheet and consent form (see Appendices 6 and 7). During July 2007, case workers handed these envelopes to all service users attending appointments at the Centre. Service users were given a fortnight to inform case workers if they were willing to participate. Out of eighteen service users who consented to participate a total of twelve attended interviews held over two days at the beginning of August 2007. A quarter of participants were female and over half of the sample had been accessing ADS services for over six months. The recruited sample was therefore a convenience sample rather than representative of the service user population. Nonetheless, their views were explored in relation to ADS services and the perceived benefits of those services, and can be viewed as illustrative of the kinds of experiences and views of other similar service users.

A letter and a participant information sheet were sent to all ADS staff inviting them to attend a focus group session. A total of five out of the six workers attended the session which took place at the beginning of July 2007. The session sought to explore workers' experiences of identifying and meeting the needs of Warrington's alcohol misusing population, and the factors, both operational and strategic, influencing their ability to do so.

Key staff from external agencies who had referred individuals during the analysis period or been involved in the development of joint working initiatives were identified by

the Community Alcohol Service's project manager and their contact details given to the researcher. In August 2007, a letter and a participant information sheet were sent to these individuals by post or email inviting them to contact the researcher to arrange a convenient time for interview. Interviews were subsequently held with key staff from mental health services, the probation service, the police, and Warrington PCT. Interviews held with two A&E consultants at Warrington Hospital that formed part of another service evaluation also sought feedback concerning their use of ADS services. In total, eight individuals from this stakeholder group contributed their views and experiences. These interviewees constituted a purposive sample: they were identified and included as key informants who had knowledge of the Community Alcohol Service.

The project received ethical approval in June 2007.

Chapter 3

Service activity data

June 2006 – August 2007

3.1 Introduction

This chapter presents an analysis of service activity over the June 2006 and August 2007 period. This analysis has been produced using data extracted from the ADS monitoring database covering the 15 month period. It reports all service activity in relation to key performance indicators for the Service identified by the PCT. Thus, this chapter reports on:

- service user characteristics;
- numbers and sources of referral;
- service response times;
- attendance rates in relation to treatment modality;
- discharge rates.

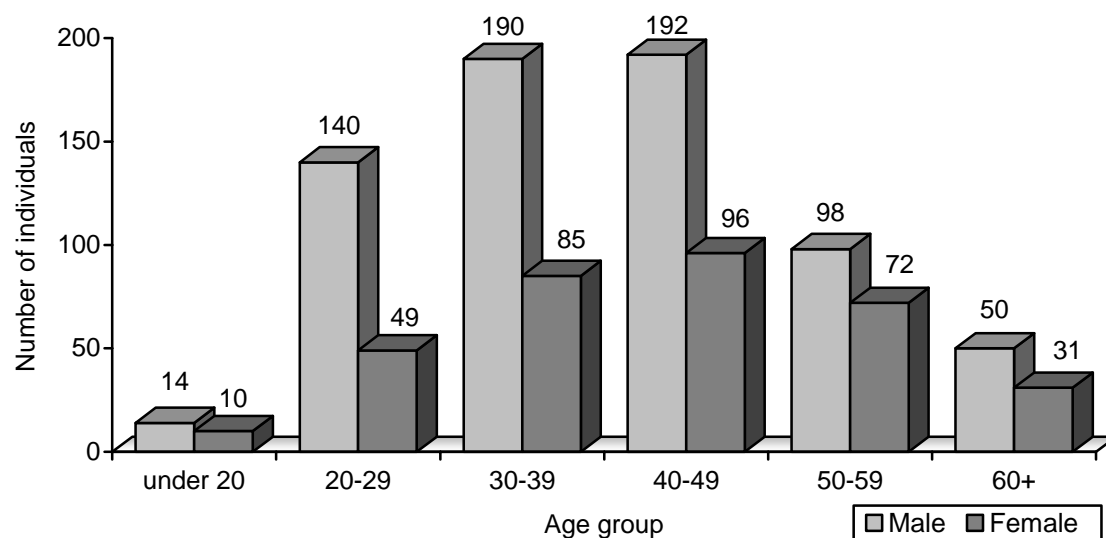
The total number of individuals on the database at the point of analysis was 1,136. Of these, 109 were referred at some point prior to June 2006 thus they are not included in the analysis of referral activity over the June 2006 to August 2007 period. All other activity reporting does however refer to the 1,136 individuals on the ADS database. It should be noted that the total number of individuals, in the calculation of percentages for different dimensions of the service activity, varies due to incomplete records. Where this is the case it has been noted in the text.

Findings in relation to outcomes are presented in Chapter 4.

3.2 Service user characteristics

Between June 2006 and August 2007 1,027 individuals were referred to ADS. Of those referred over two thirds were men (67%, 683) and a third were women (33%, 344). The age ranged from 17 through to 79 years, with the majority of referrals (55%, 563 out of 1,027) between the ages of 30 and 49 years old. Figure 3.2.1 shows the age and sex distribution of these individuals. As Figure 3.2.1 illustrates, males outnumber females in every category, but particularly in the 20-29, 30-39 and 40-49 categories, where the ratio of males to females is approximately 2:1.

Figure 3.2.1 Age and sex of individuals accessing ADS



In terms of ethnicity, the majority of the population of Warrington are White British (96%), as reported in the Census 2001 (Office for National Statistics, 2007). Table 3.2.1 illustrates the ethnicity of all individuals referred to ADS during the 15 month period, which indicates that virtually all referrals were categorised as British.

Table 3.2.1 Ethnicity of individuals referred to ADS

Ethnicity	Total	%
British	1,023	100
Irish	1	<1
Other White	1	<1
Other Asian	1	<1
Not Stated	1	<1
Total	1,027	100

3.3 Numbers of referrals

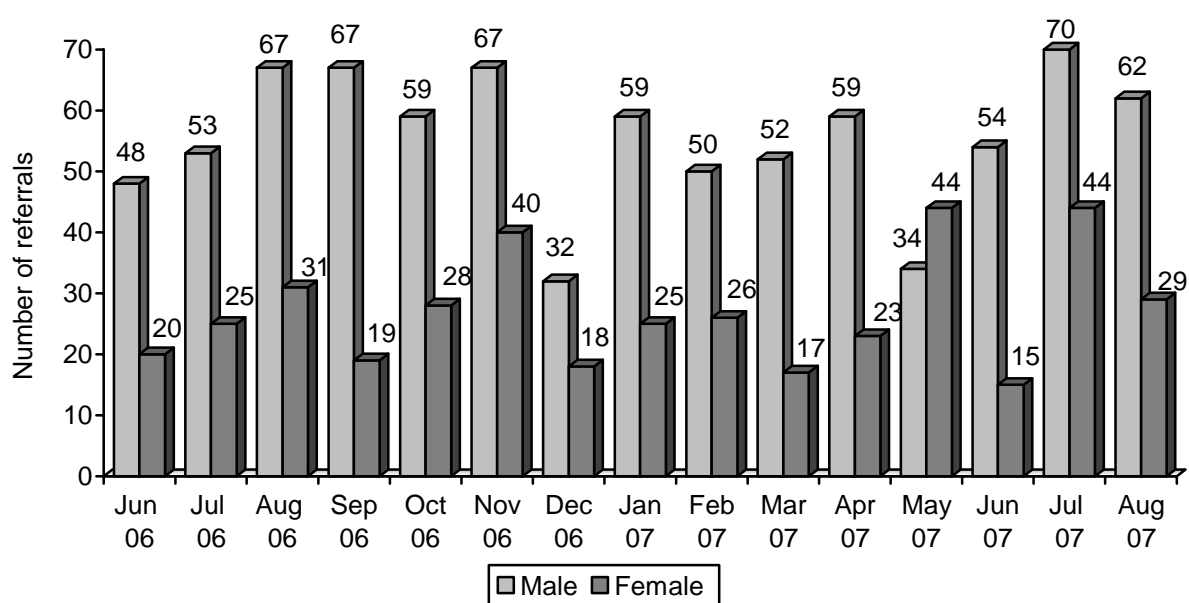
It is important to analyse service activity data in terms of number of referrals in addition to number of individuals as some service users were referred to ADS on more than one occasion during this 15 month period. Overall, 1,027 individual service users generated 1,237 referrals. Table 3.3.1 shows the referral frequency (between one and five times) in relation to the number of males and females referred.

Table 3.3.1 Referral activity by sex

Referral frequency	Males	Females	Total	%	Total number of referrals
1	556	290	846	82	846
2	107	49	156	15	312
3	18	4	22	2	66
4	2	0	2	<1	8
5	0	1	1	<1	5
Total	683	344	1,027	100	1,237

As Table 3.3.1 illustrates, the majority of individuals (82%, 846) received a single referral to ADS. However, 18% (181) were referred between two and five times. Of the individuals who had a multiple referral, 86% (156) had been referred twice in 15 months. However, it is evident that a small number of individuals generated a relatively large number of referrals. For example, 156 individuals (15% of all individuals referred) generated 312 referrals (25% of all referrals).

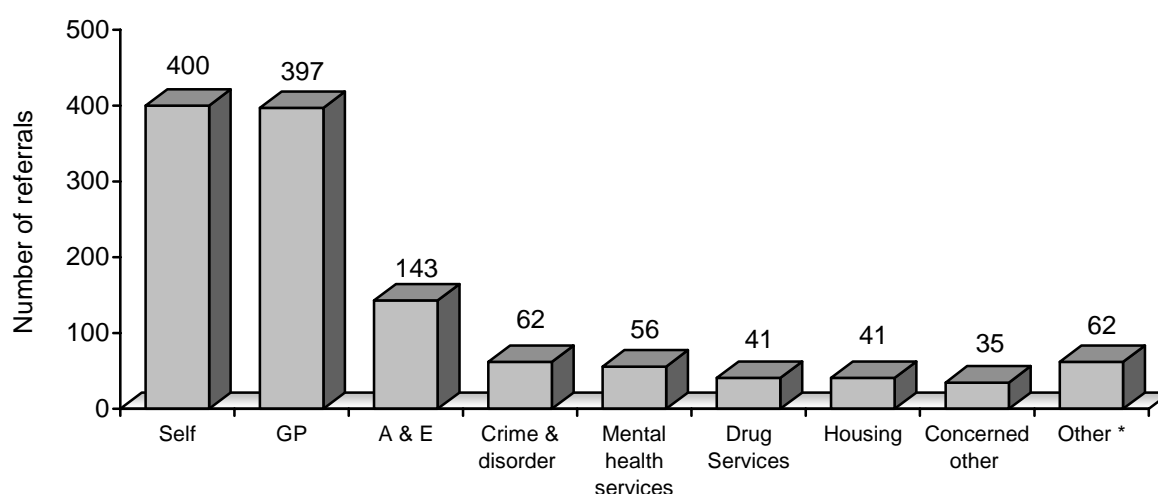
Over the 15 month period there was some fluctuation in the monthly number of referrals. Figure 3.3.1 shows the total number of referrals each month by sex. Such variation in monthly activity is not unusual – for example, the reduction in referrals during December. However, the last quarter, June to August 2007, saw a rise in the total number of referrals (274) compared with numbers for the previous two quarters (December to February, 210; March to May, 229).

Figure 3.3.1 All ADS referrals by sex between June 2006 – August 2007

3.4 Referral source

Figure 3.4.1 shows all referrals by their source, and it is evident that referrals were made from across the health and social care agencies in Warrington. Both 'self' and 'GP' referral were the two most common referral sources with each accounting for approximately 32% of all referrals. The Accident and Emergency Department – the next most common referral source – accounted for 12% (143) of referrals. Crime and Disorder (probation, police and the prison service) accounted for a further 5% (62) of referrals.

Figure 3.4.1 Referral source: June 2006 – August 2007



*Other referral sources include: ARCH/CAT, named referral agency, social services, hospital (other than A&E), primary care (other than GP), employment service.¹

Referral source was analysed in relation to the age and sex of service users and is illustrated in Table 3.4.1 and Table 3.4.2 respectively. It is evident from Table 3.4.1 that the male to female ratio of approximately 2:1 holds across a number of referral sources. However, there were some noticeable variations from this pattern, although given that the numbers in some referral source categories were small, caution needs to be exercised in interpreting these data. For example, the proportion of females referred by social services (55%, 12) was greater than for males, and, conversely, females referred through housing support agencies accounted for only 10% of their total referrals. A further point of note is the high proportion of males relative to females

¹ It should be noted that a breakdown of data entered under 'Other' as a category revealed the inclusion of some agencies already represented in the specified categories, such as primary care and hospital. It has not been possible for the purpose of analysis to add these to their 'main' category. This however should be noted when examining the source table. This is an error of categorisation and not double counting.

referred from Crime and Disorder. These patterns may reflect the different proportions of men and women who constitute the client base in these categories of organisations.

Table 3.4.1 Referral source by sex

Event Name	Female	%	Male	%	Total	%
Self	142	36	258	65	400	32
GP	141	36	256	64	397	32
A & E	43	30	100	70	143	12
Crime & disorder	4	6	58	94	62	5
Mental health services	23	41	33	59	56	5
Drug Services	13	32	28	68	41	3
Housing	4	10	37	90	41	3
Concerned other	8	23	27	77	35	3
Social Services	12	55	10	45	22	2
ARCH/CAT	5	42	7	58	12	1
Hospital	4	36	7	64	11	1
Named Referral Agency	3	30	7	70	10	1
Primary Care	3	50	3	50	6	<1
Employment Service	0	0	1	100	1	<1
Total	405	33	832	67	1,237	100

As Table 3.4.2 illustrates, the majority of self and GP referrals were with those aged between 30-39 and 40-49 years old, with 60% and 65% of all referrals respectively. In the case of A&E referrals, the majority (71%) were with those aged 40 years and over. For those referrals from Housing, Drug Services and Crime and Disorder the majority were found to be with those service users aged under 40 years old, with 74%, 76% and 61% of contacts respectively.

Table 3.4.2 Referral source by age group

Referral source	under 20	%	20-29	%	30-39	%	40-49	%	50-59	%	60+	%	Total	%
Self	6	2	78	20	118	30	120	30	55	14	23	6	400	32
GP	13	3	56	14	105	36	117	29	75	19	31	8	397	32
A & E	0	0	15	10	26	18	46	32	29	20	27	19	143	12
Crime & disorder	2	3	20	32	24	39	12	19	4	6	0	0	62	5
Mental health services	1	2	13	23	14	25	11	20	15	27	2	4	56	5
Drug Services	1	2	11	27	19	46	10	24	0	0	0	0	41	3
Housing	1	2	11	27	13	32	11	27	5	12	0	0	41	3
Concerned other	0	0	12	34	11	31	6	17	6	17	0	0	35	3
Social Services	0	0	1	5	8	36	9	41	2	9	2	9	22	2
ARCH/CAT	0	0	1	8	2	17	0	0	7	58	2	17	12	1
Hospital	0	0	2	18	2	18	3	27	3	27	1	9	11	1
Named Referral Agency	1	10	5	50	1	10	2	20	0	0	1	10	10	1
Primary Care	0	0	2	33	0	0	3	50	0	0	1	17	6	<1
Employment Service	0	0	1	100	0	0	0	0	0	0	0	0	1	<1
Total	25	2	228	18	343	28	350	28	201	16	90	7	1237	100

3.5 Initial and comprehensive assessments

Most service users are assessed through a short initial assessment and a comprehensive assessment. Both initial and comprehensive assessments can take place either in the ADS setting or the primary care setting. Data were available for 554 initial assessments that were completed during the 15 month period. Overall, 82% (453) of all initial assessments were completed in the ADS setting, with just under one in five being carried out in primary care (18%). Figure 3.5.1 shows that the pattern relating to the monthly number of initial assessment carried out was variable over the period of analysis. However, the number of initial assessments being carried out in the primary care setting declined towards the end of the analysis period. For example, during the last six months (March to August 2007) the number of assessments carried out in primary care almost halved compared to the September 2006 to February 2007 figures.

Figure 3.5.1 Initial assessments completed: setting

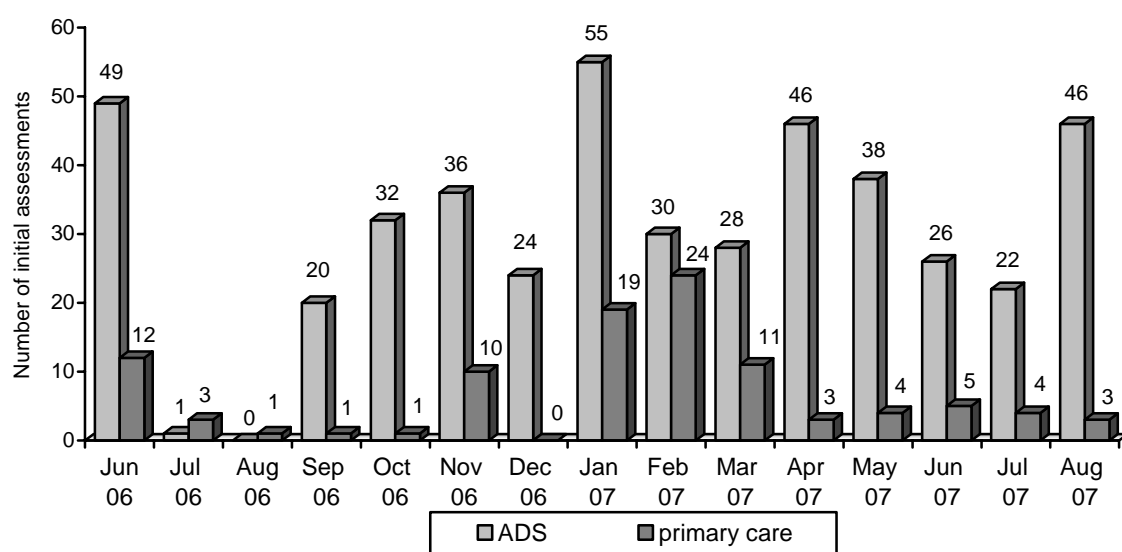
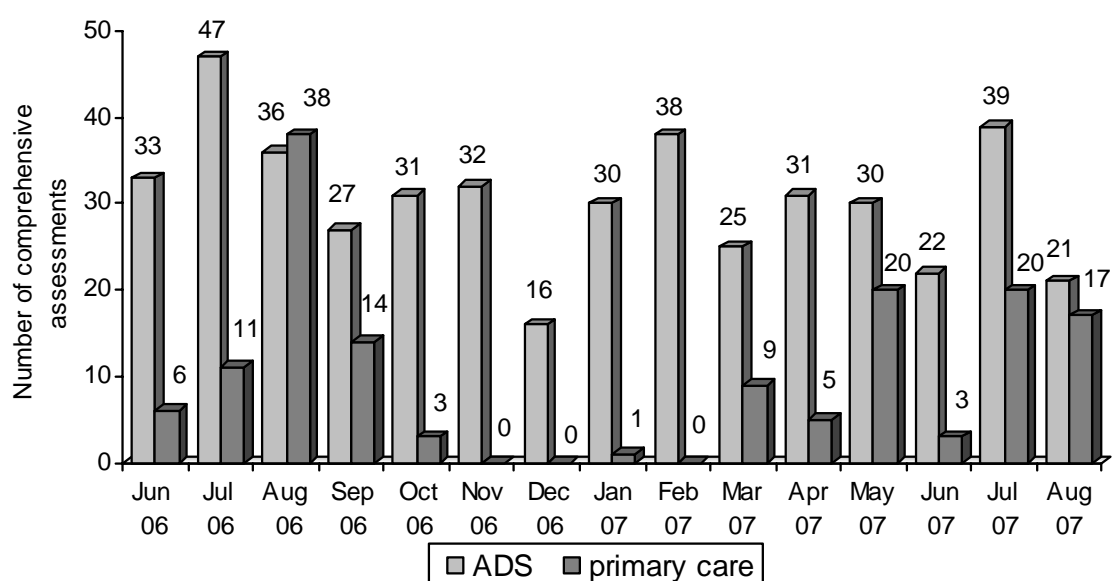


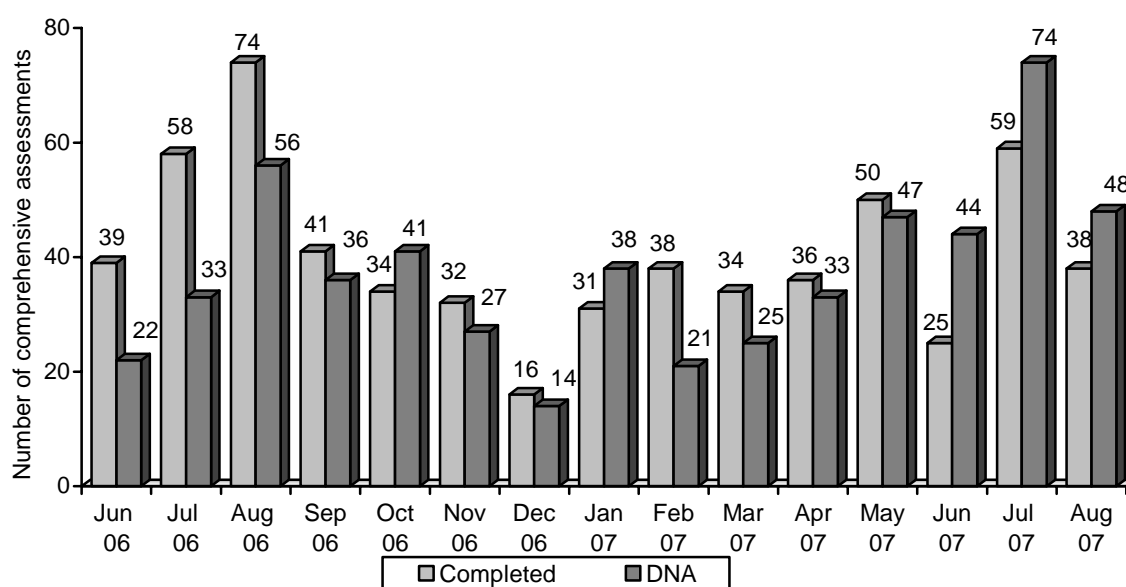
Figure 3.5.2 shows the setting in which comprehensive assessments were carried out; 605 such assessments were recorded on the database during the 15 month period. Overall, 76% (458) were carried out in the ADS setting, with just under one in four being carried out in primary care (24%, 147). The number of comprehensive assessments fluctuated in both settings over the analysis period. However, the number carried out in primary care increased in the latter half of the analysis period. Examination of the last six months against the previous six month period showed a fourfold increase in the number completed in the primary care setting.

Figure 3.5.2 Comprehensive assessments completed: setting



Attendance at the comprehensive assessment is recorded on the database. The record of those service users who failed to attend appointments was marked as 'did not attend' (DNA). Figure 3.5.3 shows the monthly number of completed comprehensive assessments (in both the ADS setting and the primary care setting) against the number of service users who did not attend their appointment. Overall, 1,164 comprehensive assessment appointments were made during the analysis period, of which 559 were not attended, giving an overall DNA rate of 48%. Figure 3.5.3 shows that the DNA rate was variable over the 15 month period, ranging from 64% in June 2007 to 36% in June and July 2006 and February 2007. The last quarter (summer), June to August 2007 saw the average DNA rate rise to 58%.

Figure 3.5.3 Comprehensive assessment: completed and DNA



3.6 Treatment activity

Service users can receive or attend more than one treatment. Table 3.6.1 shows service activity within the different treatment modalities. Figures refer to the number of sessions that were attended or not attended during the 15 month analysis period. Overall, 6,072 treatment sessions were held during this time, with an overall attendance rate of 74% (4,481 sessions attended). Thus, just over one in four sessions were not attended during this period. However, as Table 3.6.1 shows, the attendance rate varies by treatment modality.

Table 3.6.1 Client activity by treatment modality

Attendance	Counselling	%	Group session	%	Alternative Therapy	%	Detox	%	Total	%
Attended	2,596	62	955	100	748	96	182	100	4,481	74
DNA	1,560	38	1	0	30	4	0	0	1,591	26
Total	4,156	100	956	100	778	100	182	0	6,072	100

As Table 3.6.1 illustrates, counselling had the highest number of contacts with service users. A total of 548 individuals accessed counselling sessions 2,596 times over the 15 month period (4.7 contacts per person). However, of the 4,156 counselling sessions scheduled, over a third (1,560, 38%) were not attended. The DNA rates ranged from 20% in July 2006 through to 44% in May 2007. Table 3.6.2 shows a breakdown of counselling sessions attended by age group and sex.

Table 3.6.2 Counselling sessions by age and sex

Sex	under 20	20-29	30-39	40-49	50-59	60+	Total
Male	4	221	463	540	351	80	1,659
Female	13	134	173	298	253	66	937
Total	17	355	636	838	604	146	2,596

A total of 955 group work sessions were undertaken by 107 individual service users. Table 3.6.3 shows a breakdown of group work sessions attended by age group and sex. The majority (71%, 676) of sessions were attended by males; in all age groups, more sessions were attended by males than females. For those service users aged between 30 and 49 years old, 84% of contacts (347 out of 415) were with male service users.

Table 3.6.3 Group work sessions by age and sex

Sex	under 20	20-29	30-39	40-49	50-59	60+	Total
Male	0	12	165	182	201	116	676
Female	0	6	22	46	163	42	279
Total	0	18	187	228	364	158	955

Service users can access acupuncture as part of their treatment. Overall, 139 service users attended 748 acupuncture sessions, the majority of contacts (61%, 459) being with male service users. Table 3.6.4 illustrates the age and sex breakdown for acupuncture attendance over the 15 month analysis period. More sessions were

attended by males compared to females in all age groups with the exception of the 50 to 59 year age group, where 57% of contacts (170 out of 300) were with women.

Table 3.6.4 Acupuncture sessions by age and sex

Sex	under 20	20-29	30-39	40-49	50-59	60+	Total
Male	0	40	90	149	130	50	459
Female	0	2	21	62	170	34	289
Total	0	42	111	211	300	84	748

During the analysis period 182 community detoxification sessions were recorded and delivered to a total of 26 individuals, all of whom had undertaken the treatment programme. Table 3.6.5 illustrates the total number of detoxification sessions by age and sex. It is evident that all service users receiving this treatment were between the ages of 20 and 59 years old. The majority of contacts (87%, 129) were made with male service users.

Table 3.6.5 Community detoxification sessions by age and sex

Sex	under 20	20-29	30-39	40-49	50-59	60+	Total
Male	0	41	43	16	29	0	129
Female	0	10	1	32	10	0	53
Total	0	51	44	48	39	0	182

Warrington PCT has a contract for the use of 100 bed nights at The Smithfield Project, an in-patient detoxification unit in Manchester run by Turning Point. ADS manage the allocation and use of these bed nights. A decision regarding an individual's need for in-patient rather than community detoxification is taken at the initial assessment stage. Between May 2006 and August 2007 ADS referred 17 individuals to The Smithfield Project. Fourteen (82%) of these were recorded as having successfully completed their treatment programme.

Waiting times for referral from ADS to in-patient treatment was estimated as three to four weeks. The estimated length of time needed for an individual to complete a residential detoxification was 10 days. However, in cases where arrangements have been made for an individual to access rehabilitation services following completion of treatment, they can be discharged on the seventh or eighth day of their programme.

3.7 Response times

Through examining the routinely collected appointment data it was possible to identify the number of days between, firstly, referral and assessment, and, secondly, assessment and intervention. Table 3.7.1 shows the number of days from referral through to an initial or comprehensive assessment being completed. It is evident that the majority of referrals (68%, 728 out of 1,065) were given an assessment within seven days of the referral being made, with a further 24% being seen within 14 days. The mean number of days from referral to assessment was seven days.

Table 3.7.1 Number of days between referral and assessment

Number of Days	Number of referrals	%
0	110	10
1-3	224	21
4-7	394	37
8-14	251	24
15-21	63	6
21+	23	2
Total	1,065	100

It had been anticipated that it would have been possible to establish the date an appointment for a comprehensive assessment was *offered* as well as the date the appointment was *attended*. However, this information was only available for 178 cases. In the case of the 178, 86% were given an assessment date within seven days of the referral being made. The mean number of days from referral to comprehensive assessment was five days.

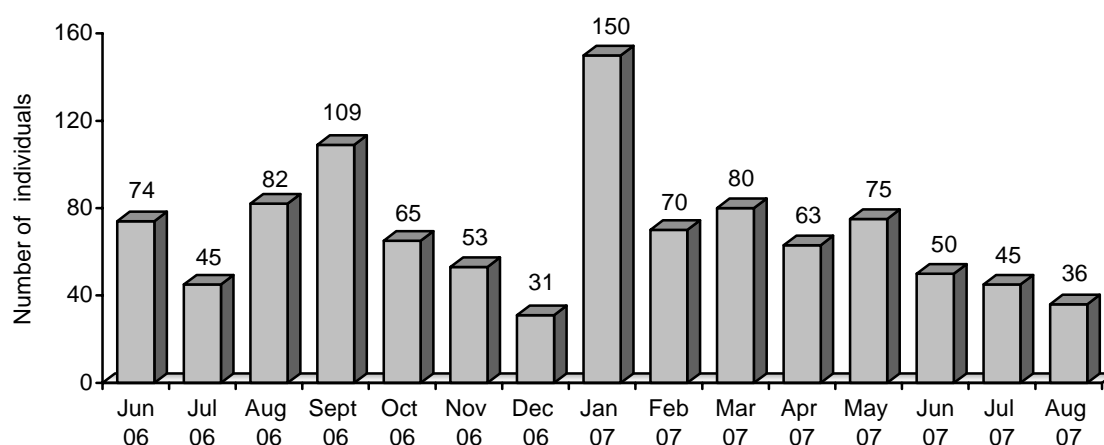
Table 3.7.2 illustrates the data in relation to the response time from assessment to first intervention. It is evident that the majority of service users (78%, 465 out of 599) received a treatment within 14 days of their assessment being completed. Of these 50% (298) were seen within seven days. The mean number of days from assessment to first intervention was 13.

Table 3.7.2 Number of days between assessment and first intervention

Number of Days	Number of service users	%
0	26	4
1-3	35	6
4-7	237	40
8-14	167	28
15-21	58	10
22-28	35	6
29+	41	7
Total	599	100

3.8 Discharge rates

Cases were closed and recorded on the ADS database as 'discharged' from the service either because their care plan was completed or because they had dropped out of the service. It was not possible to distinguish the numbers in these two groups from the database. Figure 3.8.1 shows the number of service users who were discharged between June 2006 and August 2007. Overall, during the 15 month period 1,028 discharges were recorded, of which 703 (68%) were male and 325 (32%) were female. These 1,028 discharges relate to 847 individuals, indicating that a number of individuals had been discharged on more than one occasion. Given that 1,136 individuals accessed the Service during the 15 month period, at the end of August 2007, 289 individuals were still active ADS service users.

Figure 3.8.1 Cases discharged between June 2006 and August 2007

As Figure 3.8.1 illustrates, the number of cases discharged fluctuated throughout the 15 month period. Table 3.8.1 presents a breakdown of multiple discharge rates. It is evident that 27 individuals accounted for 87 discharges.

Table 3.8.1 Total number of discharges by individual service users

Discharge frequency	Number of individuals	%	Total number of discharges
1	699	83	699
2	121	14	242
3	23	3	69
4	2	<1	8
5	2	<1	10
Total	847	100	1,028

Chapter 4

Outcomes

4.1 Introduction

The service user outcomes for the Warrington Community Alcohol Service related to the aims and objectives identified in the service specification, namely:

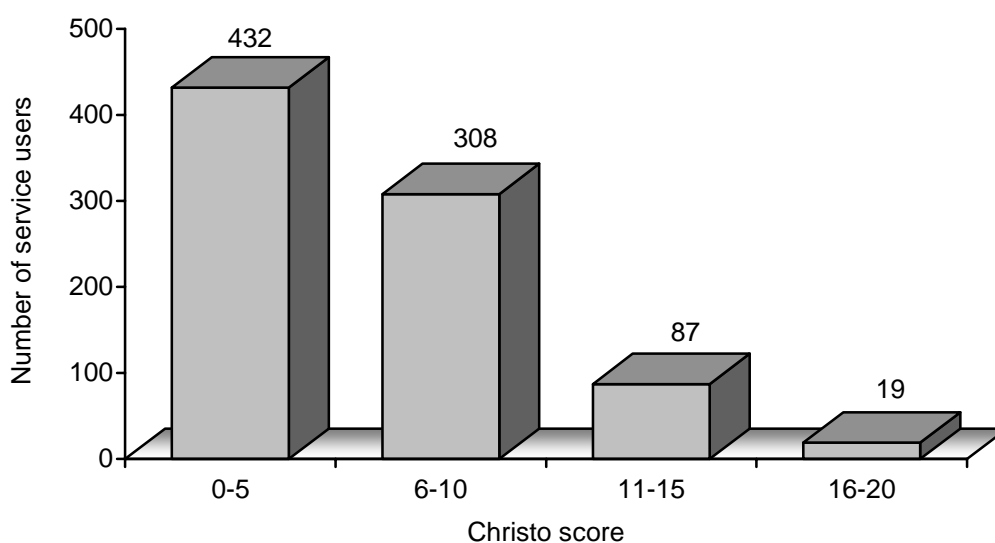
- improving physical and mental health;
- improving social and family functioning;
- reducing the harm to the individual and concerned others;
- reducing the rates of mortality and hospital/GP attendances. (Warrington PCT, 2005, p.6).

This chapter presents the findings in relation to outcomes.

4.2 Outcomes for service users: Christo scores

The Christo tool comprises ten questions which aim to assess the impact of an individual's dependency on different aspects of their lives, namely: alcohol use, criminal activity, mental and physical health, living situation, occupational activities and support. Baseline Christo scores are presented in Figure 4.2.1 for the 846 services users for whom they were available.

Figure 4.2.1 Baseline Christo scores



Overall, 51% of service users (432) had a total Christo score of between 0 – 5. A high score will generally reflect greater alcohol dependence whilst a lower score indicates a lower degree of dependence and, in some cases, abstinence. Lower scores at follow-up may also reflect the impact of abstinence.

Baseline and follow-up Christo scores were available for only 175 service users for the fifteen month period (118 males and 57 females). A paired score difference was calculated by comparing the total score (sum of all ten question scores) taken at comprehensive assessment and again at the case review stage. The majority of services users (85%, 148 out of 175) had a decrease in their Christo score at case review. However, for a minority there was either no change or an increase at the case review stage: 14 (8%) service users' scores remained the same and 13 (7%) increased.

Table 4.2.1 shows the mean scores (standard deviation) for males, females and the cohort of 175 service users as a whole. The mean change in Christo score between the assessment stage and the review stage was a reduction of 4.1. This change in scores was highly statistically significant ($P < 0.0005$).

Table 4.2.1 Mean (SD) Christo scores at baseline and follow up for males, females and combined

	Male (SD)	Female (SD)	Combined (SD)
Assessment (baseline)	7.4 (3.9)	6.8 (4.1)	7.2 (3.9)
Case review (follow up)	3.3 (2.9)	2.7 (2.9)	3.1 (2.9)
Mean score difference	-4.1 (4)	-4.2 (3.4)	-4.1 (3.8)

4.3 Alcohol consumption

To measure progress at case review, service users were asked about their alcohol use. Table 4.3.1 shows consumption details recorded at case review. Self-reported alcohol consumption data were available for 269 service users (176 male and 93 female). 'Abstention' was defined as having consumed no alcohol within the last seven days prior to review. Overall, 72% (193) of the 269 service users recorded abstinence at case review. There were no differences in abstinence rates between female and male service users.

Table 4.3.1 Alcohol use at case review by sex

Alcohol use	Male	Female	Total	%
Abstinent	127	66	193	72
Current dependence and use	24	14	38	14
Continuous use	9	6	15	6
Episodic use (binge drinking/using)	6	6	12	4
In prescribed treatment	10	1	11	4
Total	176	93	269	100

Table 4.3.2 shows alcohol use at case review by age group. The percentage of those aged over 20 abstaining from alcohol ranged from 67% in the 20 to 29 age group through to 89% in the 60 plus age category.

Table 4.3.2 Alcohol use at case review by age group

Alcohol use	under 20	20-29	30-39	40-49	50-59	60+	Total
Abstinent	1	22	43	54	48	25	193
Continuous use	0	1	5	4	5		15
Current dependence and use	0	5	6	12	12	3	38
Episodic use (binge drinking /using)	0	3	3	4	2	0	12
In prescribed treatment	0	0	7	4	0	0	11
Total	1	31	64	78	67	28	269

During qualitative interviews participants were asked how their involvement with the Community Alcohol Service had impacted upon their drinking. Eight of those interviewed reported total abstinence whilst the remaining four participants reported that they had significantly reduced their consumption with two reporting frequent periods of abstinence.

4.4 Services users' views of the impact of the Service

The impact of the Service was explored with 12 service users during the interviews (see Appendix 3 for the interview schedule). They talked about the impact of the Service in relation to their mental health, physical health, improved social and family functioning and the prevention of relapse. These qualitative outcomes are explored in more detail below. Those aspects of the Service that were perceived to have contributed to their improved health and well-being are also discussed.

4.4.1 Mental health

When asked what impact they thought their involvement with the Community Alcohol Service had had on their health, service users responded in terms of the improvements they had observed in their general mental health. Improved self-esteem and confidence, along with reduced anxiety, were the most commonly cited aspects of mental health that service users thought had improved due to their involvement in the Service. They specifically identified participation in counselling, the aftercare group programmes and peer group support work. For example, one participant described the effect that her improved confidence had had on her ability to discuss her dependence:

'I'll talk about the alcohol now because they make you feel good about yourself so you feel confident. When you drink you hate yourself, you detest yourself. I don't feel ashamed of myself anymore.' (Service user 4).

Service users spoke about their experience of suicidal feelings and actual suicide attempts. These participants highlighted the role that the aftercare group programmes and supportive group environment had played in helping them to identify triggers and address feelings of low self-worth and anxiety. Interviewees spoke about their experience of depression and mental health problems which, for some, had brought them into contact with mental health services (although they were no longer in contact with these services). Two participants, whose alcohol-related violent behaviour had led to job loss, described their improved ability to manage their anger and avoid volatile situations; one described it thus:

'All my life if there was a problem I'd go straight down the pub. Now I've learnt breathing exercises, positive mental attitude, you know.' (Service user 8).

Service users attended activities at the Centre two, three or four times a week. In addition to the structure they thought this provided to support them in their efforts to pursue an alcohol-free lifestyle, the support offered by peers was also cited as key in building confidence and feelings of self-worth.

Service users also spoke of the beneficial effect of acupuncture treatments on their feelings of mental well-being. Many highlighted the importance of acupuncture to them and their frequent visits to the Centre to access this specific service.

4.4.2 Physical health

Service users, when considering the physical effects of abstinence or reduction, commented on the link between their improved mental health and their physical well-being. Observations were made of an increased willingness to engage in more activities outside the home due to feelings of increased confidence and self-worth. For example, some interviewees said they had started to cycle instead of taking the bus and two participants had started exercising because they had felt better in themselves. The link between physical and mental health is illustrated in the following quotation from a service user:

'I've re-learnt self-esteem and confidence. The anxiety group has meant the world to me, I'm a different person, I've lost three stone and I wake up feeling wonderful.' (Service user 3.)

The issue of diet and nutrition, a feature of personal development sessions, was identified by several service users. Many attributed improved feelings of physical well-being to a renewed interest in both eating and cooking.

4.4.3 Improving social and family functioning

Service users were asked how they thought their engagement and involvement with ADS had affected their day-to-day life. The observation was made that making the step in seeking, and more importantly, receiving, help had led to them adopting a more proactive approach to other day-to-day activities. Responses repeatedly referenced the instrumental role that improved confidence had played in improving overall functioning. Service users spoke of the energising and motivational effect that a group discussion could have on their willingness to tackle something previously avoided, for example, tackling domestic chores, getting on a train or even parking their car in a multi-storey car park. One participant who had been out of work for some time observed:

'They've given me the confidence in myself to go for my fork lift truck licence and I passed it, I'm with an agency now and picking up day and night work.' (Service user 5).

Assertiveness training accessed at the Centre was also cited as instrumental in developing service users' ability to engage in activities outside ADS. One participant observed how his willingness to do more had resulted in him looking forward to the day ahead. Two participants said confidence had prompted them to revive past friendships and discarded pastimes.

Service users were asked if they thought family and close friends had benefited from their involvement with ADS. All but two participants interviewed expressed the view that engagement had helped those close to them. Examples given to illustrate this included situations where abstinence had prompted siblings and family members, previously estranged due to past behaviour, to offer gestures of support and concern. They also cited examples whereby maintaining abstinence had saved their marriage and thus meant that they had been able to stay with their children. Assertiveness skills learnt at group sessions had helped one interviewee, experiencing problems with demands from family members, to encourage these individuals to respect his boundaries.

Only two of the interviewees had family members who had accessed ADS services as a concerned other. Both of these commented on the positive effect which this had had on easing tensions in the home that had arisen from issues around their alcohol misuse. One person observed that his partner's increased understanding of alcohol misuse had led to her offering a level of support during a recent relapse which he felt had enabled him to return to abstinence.

4.4.4 Relapse prevention

For many, an important element of treatment had been the education they had received around relapse. One interviewee described the difference that learning to accept and understand the causes of relapse had made in enabling him to maintain a positive attitude and return to abstinence. Another service user described it thus:

'I used to panic if I relapsed – they teach you not to and that helps you feel good enough about yourself to start again.'
(Service user 1).

Several service users commented on the role that keeping a drink diary had played in opening their eyes to the extent of their alcohol dependence. Another benefit reported from carrying out this task had been the realisation of the damage such consumption levels would be doing to their health and, indeed, their day-to-day functioning.

Chapter 5

Service processes

5.1 Introduction

This chapter presents findings from the qualitative interviews with all the stakeholder groups. The qualitative data analysed was gathered during a focus group held with five ADS staff; interviews with eight external agency staff and; interviews with 12 ADS service users. Through examining the whole service delivery process, from referral to discharge, the aim is to illustrate the ways in which service processes have worked to engage service users and, in so doing, maximise the chances of generating positive outcomes for service users and their families.

5.2 Referral processes

All service user participants were asked for their views and experiences of the referral process. Nearly half of the service users interviewed had 'self-referred' and one third had been referred by their GP. One participant who had suddenly stopped drinking had been referred to the service by an A&E doctor following his seeking emergency treatment. Another had been referred by his probation officer who had arranged an appointment for him the week after his release from prison. The remaining service user had transferred from the previous Community Alcohol Service. Participants from the mental health team reported that they would encourage their service users to refer themselves to ADS. Following their engagement with the service, key workers from both agencies would liaise to discuss service user progress. Staff reported an average waiting time for assessment of a couple of days. Probation service participants confirmed that a referral to ADS, normally made by telephone, would need to be prompted by the offender's acceptance of the problematic nature of their alcohol use.

5.3 Accessing treatment: hazardous and harmful drinkers

Since the commencement of the Community Alcohol Service, a key strategy has been to cement joint working arrangements with GPs through securing the placement of ADS workers in surgeries. The primary aim of this strategy has been to promote the use of a care pathway whereby GPs identify hazardous and harmful drinkers and offer them a practice-based appointment with an ADS worker. A secondary aim of the strategy has been to equip primary care staff with the training for delivering brief interventions. Discussion with ADS staff revealed that arrangements were in place with

eleven out of the 28 practices in the Warrington area. Although training had been offered to all GP practices, ADS was still working towards the establishment of arrangements in every GP practice. Those ADS staff with experience of working with GP surgeries described the difficulties of this task. Attention was drawn to the need to promote understanding and acceptance of the role of primary care in identifying and treating hazardous and harmful drinkers. Staff said that a variety of reasons were offered by GPs for not placing a worker at their practices, mostly centred on accommodation and resources.

Discussions across agency interviews revealed a view that GP responses to the needs of hazardous and harmful drinkers in Warrington was somewhat patchy. For example, the following observation was made:

'Depending on the individual's GP it depends what service they get or what they are offered. Some GPs are really good and others are very dismissive of the person they're dealing with.'
(Probation officer).

Participants from the probation service described their delivery of a form of brief intervention to service users where a referral to ADS was not appropriate but where alcohol misuse was a factor in the individual's behaviour. It was explained that the discussion of drinking behaviour, identification of triggers and coping mechanisms in cases of pre-dependent drinkers was considered part of the probation process. These participants highlighted the role that alcohol misuse often played in incidents of domestic violence.

5.4 Engagement with the Service

Service users were asked about their first experiences of accessing the Service. Whilst feelings of fear and trepidation prior to their first attendance were commonly described, all of those interviewed commented on the welcome they received on that and subsequent attendances. As one service user observed:

'The way they were that first day and the way they still are, it made all the difference in me being able to come over the step because that's what makes or breaks you, getting over the step to get the help.' (Service user 3).

Service users referred to the informality of the Centre and the immediate friendliness of both staff and other service users. Demonstrations of generosity and trust were referred to as evidence of a general atmosphere of warmth and inclusiveness. Those for whom their first contact had been with a primary care-based worker spoke of the

informal, relaxed tone of sessions. They also described the importance of feeling both respected and accepted regardless of their alcohol misusing behaviour. As evidence of the relaxed and friendly approach of ADS workers, attention was drawn to their full participation in trips organised by and for service users. Days out identified by service users included visits to Crosby beach to view Anthony Gormley's sculptures and a visit to Chester Zoo.

5.5 Response times and service flexibility

In discussions with service users, the issue of a timely response when approaching the service was highlighted as a contributing factor in strengthening their motivation to address their alcohol misuse. Service users reported having been seen by somebody within a few days of their referral to the service. The short wait between referral and invitation to appointment was highlighted by many as a key factor in motivating them to attend the Service. One respondent described her experience thus:

'They gave me an appointment for that afternoon; if they hadn't I know I wouldn't have had the courage to come back the next day. I had been in denial for so long I needed an immediate response and I got it.' (Service user 6).

The benefits of a timely response were also illustrated by some of the referral agency staff who gave specific examples of the way in which a swift response had engaged service users. For example, one probation officer interviewed described the experience of a recent offender with severe alcohol misuse issues. This individual, charged with domestic violence, was required to attend ADS. A relapse resulted in his admission to hospital; when discharged an immediate referral was made to ADS and he was seen that day. He currently accesses the Centre twice weekly.

Discussion with external agency workers revealed a high level of satisfaction with the flexibility of the service. One worker observed that the drop-in approach to accessing Centre activities increased the potential for a timely response to be made. Discussion also took place about the fact that service users were encouraged to remain involved with the service during relapses. Reference was made to previous alcohol services where the policy was to exclude individuals during relapse, thus losing contact with an already high risk and vulnerable group. The ADS approach described was that, whilst not allowing intoxicated or unmotivated individuals to attend treatments or group activities, these individuals were still encouraged to keep in contact with the Centre by telephoning or popping in for a coffee and a chat. The view was expressed that this

continued support and acceptance optimised the likelihood of these individuals re-engaging in treatment.

Service users interviewed were asked for their views on the support offered by the Community Alcohol Service. All were emphatic in expressing their high level of satisfaction with the level and nature of support offered. Service users identified the level and appropriateness of support as vital elements in their continued ability to tackle their alcohol misuse. For one participant, her willingness to move things on in reducing and eventually abstaining from alcohol at an earlier stage than first planned was prompted by her confidence that she could pick up the phone at any time. The quotation from the following participant illustrates a view expressed by the majority of participants regarding the ease with which case workers could be contacted:

'I've had so much support I know that I can come here and talk to people, I feel comfortable coming here. They're rushed off their feet but they still make time for you, without this place I don't know where I'd be.' (Service user 2).

The majority of service users were also keen to describe their feelings of gratitude for the consistency and flexibility of support offered by all staff at the Centre. Although the role of the Centre workers in facilitating groups was valued, many participants spoke of the feelings of user-ownership regarding the groups they attended. One participant described it thus:

'I think a lot of it here is about empowerment and decision making. Take the groups, there are rules that the Centre set and then we make our own rules within the group, what we think will make it work best.' (Service user 6).

5.6 Care planning

During the comprehensive assessment stage, the service user and case worker agree a care plan, which identifies and records the individual's goals and targets whilst involved with the Service. Service users were asked about their experience of the care planning process and the extent to which they felt they had worked in partnership with their case worker in agreeing and reviewing their care plan. All said that they had been fully involved in the decisions made regarding their chosen plan. Many referred to an approach by which the case worker suggested a pathway that might be appropriate and manageable and they themselves could decide whether it was suitable or needed revision. One participant described the process thus:

'They don't tell you what to do, they listen to you and then put you on the right road.' (Service user 7).

ADS staff were asked what issues were of primary importance when identifying and planning an appropriate care pathway for a service user. The main consideration described was putting the service user at their ease in order to assess accurately their needs. Trust and confidentiality were also considered important. Reference was made by workers to the need for pursuing an individualised approach to assessing need and producing a care plan. One participant described it thus:

'We try to deliver an almost tailor made service to meet their individual needs at this stage of their recovery. Each client is an individual and deserves to be treated as such.' (ADS project worker).

The quality of ADS assessments was observed by the mental health workers interviewed to be instrumental in securing service users' engagement with the service. Successful assessments were linked to the accurate identification of often complex needs and reference to evidence-based practice in developing care plans. The following quotation illustrates this point:

'Now we've really got something – an agency that knows what they're doing and one we can totally trust. They are absolute experts, they use good assessment tools and their assessments are always spot on.' (CMHT worker).

For the majority of service users, their initial involvement with the Community Alcohol Service involved one-to-one counselling sessions with a case worker. Several service users spoke of the effect this intense work had on building confidence, which then enabled them to participate fully in the group sessions. This is described in the following comment by a service user:

'The one-to-one sessions are very helpful to talk to someone in confidence so they build up your confidence, then you know in the group sessions, you're more confident to talk to the others.' (Service user 4).

All service users interviewed had attended group sessions at the Centre, comprising a ten or twelve week rolling programme aimed at equipping them with skills to avoid relapse. The groups were run by case workers who offered instruction in areas such as anxiety management, motivational enhancement, cognitive behavioural therapy, and personal development. Support groups were also available, such as an informal drop-in group, and a 'closed' support group. The closed group was accessed through case worker referral and only open to service users who have realised changes in their drinking behaviour. This group was facilitated by service users who had been abstinent for a minimum of one year. Group sessions were identified by many as a key factor in their ability to remain motivated, positive, and, in many cases, abstinent. This was

illustrated in the following comment from a service user who had struggled to address her alcohol dependency for nearly twenty years:

'It's easy to do detox because the hospital take control, but I know from previous experience that without the support groups and acupuncture kicking in I would have been back to square one.' (Service user 3).

Participants who had accessed home detoxification services delivered by the community nurse described their experiences of care. Two of these individuals explained that they had abruptly stopped drinking before coming to the Centre, unaware of the danger of doing so. Initial treatment had thus focused upon addressing the effects of their sudden withdrawal and identifying an appropriate care plan. These participants commented upon the high level of support both through home visits during home detoxification and afterwards in Centre-based sessions with the nurse. They identified this support as key in the success of their withdrawal.

Service users discussed their previous experiences of alcohol treatment services. Reference was made to the lack of support and 'back-up' which they felt had hindered a positive outcome. Those who had sought help commented upon the negative effect that a long waiting time had had on their experience.

5.7 Collaboration and cooperation

External agency participants were asked for their views on the approach of ADS to developing and promoting a more cohesive approach to meeting the needs of Warrington's alcohol misusing population. Their responses are explored below in relation to the different agency perspectives

5.7.1 Mental health services

Interviewees from the community mental health team spoke at length about their positive experience of working collaboratively with ADS. The view was expressed that the organisation's knowledge and experience of mental health issues had been invaluable in establishing a fruitful joint working relationship. Two collaborative working groups had been set up between ADS and mental health services. One was an Alcohol Steering Group relating to hazardous and harmful drinkers who had a mental health diagnosis. This group was a forum for information sharing and identifying appropriate strategies and approaches to meeting complex needs. The second collaboration was an Alcohol Support Group, which was akin to a case conference regarding those

individuals known to both ADS and mental health services whose treatment would benefit from joint working. The majority of individuals whose situations would be discussed by this group were mental health service users who had alcohol misuse as a complicating factor and thus were highly vulnerable to abuse and exploitation. One worker described the importance of these groups in reducing risk and harm:

'The fact is that some of these people will die as a result of their vulnerability, some already have, and this, our collaboration, can give them the best possible chance of appropriate support.'
(CMHT worker).

5.7.2 Crime and disorder

Discussion with key agency staff involved in the Crime and Disorder Reduction Partnership detailed the increasingly close liaison and joint working with criminal justice agencies with regard to the treatment of alcohol misuse amongst offenders. These included a planned trial of Alcohol Treatment Requirements whereby a requirement is placed on alcohol misusing offenders to attend ADS as part of their community-based sentence. This initiative, funded by the police service, involved ADS providing protected time for individuals referred by the police or courts. Prior to the formalisation of this arrangement the offer of protected appointment time had been operating informally with some success. Under this informal arrangement eligible individuals, brought to the custody suite, are given an appointment to attend ADS at a specified time on a Wednesday afternoon of the following week. In addition to the use of this pre-booking system for arrests and apprehensions taking place in and around the town centre, it was also employed by the team of officers dealing with incidents of domestic violence. Prolific and other Priority Offenders for whom there was a dedicated police unit, were also a target for referrals to ADS.

One interviewee spoke of the gradual shift in attitude of the police regarding their role in dealing with alcohol misusing offenders, from purely punitive to preventative:

'Now the message is becoming clearer that it's not just about locking up, it's also about referring on.' (CDRP member).

Discussion with key workers from the probation service revealed the view that alcohol was the prominent issue in the lives of many of their substance misusing offenders. The following view was expressed and supported by a fellow worker:

'There are more resources for drug users than alcohol users, we've always said that and yet, in the majority of cases I deal with when it comes to substance misuse it's alcohol not drugs.'
(Probation officer).

As with mental health services, liaison between an individual's probation officer and a key ADS worker took place during their involvement with the Community Alcohol Service. It was explained that progress was discussed and monitored as part of ongoing probation work.

5.7.3 Hospital services

ADS staff described a recently agreed joint working arrangement concerning the treatment of alcohol dependent patients prescribed Librium to address the symptoms of detoxification whilst under hospital care. Previous prescribing policy focused upon managing care whilst in the hospital setting rather than the establishment of arrangements for continuation and completion of detoxification after discharge. Feedback from mental health staff also identified problems with the Hospital's previous approach to the treatment of alcohol dependent patients. Discussion with both ADS and mental health staff highlighted concerns regarding the increased risk to the patient and the opportunity missed due to lack of follow-up. Under the new arrangement, when administering Librium to alcohol dependent patients, the hospital contacts ADS to take over the management of a community detoxification. The development and implementation of this new protocol has also involved key staff from Warrington Hospital's Alcohol Liaison Project.

During interviews with two A&E consultants, conducted as part of a separate service evaluation, participants were asked about their experience of referring patients to the Community Alcohol Service. Both participants described the more cohesive response to treatment pathways for alcohol misuse since the introduction of the Community Alcohol Service. Comments were made regarding the inadequacy of the previously fragmented approach to delivering community alcohol services and one participant thought that alcohol services were now 'crystallised'. Both participants had referred patients to ADS for both detoxification and the dependent drinkers service and comments were made regarding the proactive approach of the Service in liaising with the Hospital. Reference was also made to the way in which the ADS volunteer service was cementing better links with the community. One of the consultants had been involved in the development of clearer guidance on care pathways for those who misuse alcohol. Collaboration had also taken place with ADS to produce a pathway for the discharge of those who misuse alcohol from hospital care. This had initially been rolled out with A&E staff with a view to its introduction across all hospital departments.

5.8 Future service development

Service users were asked for their suggestions for improving the current Community Alcohol Service. In referring to their previously expressed level of satisfaction, participants suggested the introduction of more days out.

Several participants observed that, although offering high levels of support, staff were in their view extremely busy. Thus, suggestions for increasing the number of workers at the Centre could be seen as a desire to relieve pressures on staff rather than a reflection of any dissatisfaction with the support offered. Some service users emphasised that unsuccessful outcomes were down to them rather than the fault of the service itself. This view is illustrated in the following comment:

'Look, you can't help people unless they want to help themselves; there is nothing more this place can do than they do already, you'll get nothing but praise from me for them I'm sorry'. (Service user 1).

The issue of workloads was also raised as a concern in feedback from ADS staff. Staff commented upon the physically and mentally tiring effects of working in organisations where, due to the nature of the service user group, success was linked to the provision of timely responses to those seeking help and support.

Key workers from mental health services identified a need for outreach work for those individuals whose mental health problems prevented them from accessing services. It was observed that for many of these individuals, addressing their alcohol misuse would greatly improve their day-to-day functioning and thus potentially reduce their use of primary and secondary health care.

The view was expressed in interviews with key agency staff that any outreach service would need to focus part of its strategy on the needs of women. In observing the high number of female offenders with alcohol misuse issues, staff from the probation service pointed to the difficulties that women with childcare responsibilities had in accessing Centre-based services. The view was also expressed that, regardless of childcare responsibilities, women would potentially be more likely to access a service delivered in or nearer their home.

5.9 Scope of the Service

Staff from mental health services highlighted the difficulties that arose for workers when trying to address the needs of individuals who present in primary care with symptoms of depression but, due to alcohol misuse, cannot be prescribed anti-depressants or access mental health support. While this stance amongst primary care workers was supported by the mental health workers interviewed, a need was identified for an appropriate strategy for meeting the alcohol treatment needs of this group in order to address their mental health issues. These participants also expressed support for the continued development of the aftercare support element of the service. A reduction in the numbers of individuals accessing rehabilitation services, for which the community mental health team are gatekeepers, was attributed to the post-detoxification support offered by ADS.

All external agency participants highlighted their support for strategies to improve the response of primary care services to the needs of hazardous and harmful drinkers. Agency workers repeatedly cited GP surgeries as the most common entry point for those seeking help. Participants also emphasised the need to secure GP commitment to the identification and treatment of hazardous and harmful drinkers. ADS staff described continuing efforts to engage all GP surgeries in strategies to identify and deliver brief interventions to hazardous and harmful drinkers. The strategy adopted to date had included presentations, training days and written correspondence. In recognising the need to improve the use of care pathways for alcohol misuse, one stakeholder interviewed expressed concern regarding the ability of the current service to continue to offer a timely response if this improvement brought about the desired increases in referral rates. Another interviewee, discussing the increased recognition of alcohol as a major trigger in the behaviour of many repeat offenders and thus anticipated growth in offender referrals to the Service, pointed to the importance of a timely response. This is illustrated in the following quotation:

'If we can offer them something there and then we don't want to miss that opportunity particularly if they are wanting that help themselves. We need to be able to send them somewhere immediately.' (CDRP member).

The need for services appropriate for the needs of binge drinkers, perceived as an increasing problem in Warrington town centre, was discussed in interviews with probation officers. Whilst health risks, coping mechanisms and safety were currently discussed in probation sessions the point was made that more focused interventions

should be delivered by specialist workers. Equally important in preventative work was believed to be the strengthening of links with youth services.

Chapter 6

Discussion

6.1 Introduction

The role of the Centre for Public Health Research has been to facilitate a formative and summative evaluation of Warrington's Community Alcohol Service as delivered by ADS. Since the introduction of the Service, the Centre has been involved in the monitoring and review of its performance. This final evaluation report provides an analysis of the processes and outcomes of the Community Alcohol Service. This chapter identifies and discusses the issues that have emerged from the evaluation in terms of their implications for policy and practice. The chapter starts with a consideration of the necessity for an improved data monitoring system if the service is to be able to provide evidence of its achievements.

6.2 Data management

As detailed in the Interim Report (Mann & Thurston, 2007), Stages One and Two of the evaluation focused on the identification and development of monitoring systems to meet the Service's reporting requirements. Whilst the process of identifying and selecting appropriate indicators for analysis was successful, the system provider's withdrawal of technical support impeded the modification of the database. Furthermore, the appointment of a new system provider has not taken place. Thus, the modification of the database was not possible, making data extraction and analysis difficult and more complex than would otherwise have been necessary. This has meant that the Service has not been able to report against the key performance indicators agreed in a robust and timely manner. The main reasons for this are outlined below.

First, the issue of workload pressure on the individual responsible for IT support at ADS has been evident during this evaluation. It would appear that, due to the loss of technical support, the task of producing statistics for national and regional monitoring purposes has been considerably increased. This has possibly impacted on the capacity of this individual to devote time to exploring and developing processes for meeting the specific reporting needs of this project. A consequence of this has been that supplementary data collection needs identified in Stage One and Two, namely, 'recorded concern' and 'previous agency involvement' could not be added to the system. Second, analysis has also been hindered by incomplete and missing data; this

has particularly affected analysis of response times and Christo scores. If data monitoring is to be carried out robustly, there is a necessary cost to this work in terms of the required human resource for inputting and analysis. This also assumes that front line staff also routinely record service activity and outcomes.

6.3 Community Alcohol Service achievements

A key aim for the Community Alcohol Service, commissioned in March 2006, was to contribute to the reduction in figures for alcohol-related use of hospital services. The past several years have seen a continuous rise in figures for alcohol-related admissions with both 2004/05 and 2005/06 showing an increase of around 28% (LPSA 2 Forecast Monitoring document, 2007b). Target performances for 2006/07 and beyond were therefore focused on a reduction in the average percentage increase. Projections for 2006/07 were calculated on an average percentage increase of 16.9%. Actual admission data produced for 2006/07 have, however, shown an increase of only 4.5%. A hospital-based brief intervention service, launched in July 2005, and targeted at hazardous and harmful drinkers attending Warrington A&E department, has also aimed to reduce the alcohol-related use of hospital services.

Analysis of both quantitative and qualitative data suggested that, once engaged with the Community Alcohol Service, successful outcomes for service users were likely. For example, analysis of data based on active clients (269), indicated that three out of four service users reported abstinence at case review stage. In addition, Christo scores for 75% of service users showed an improvement in relation to such aspects as alcohol use, criminal activity, mental and physical health, living situation, occupational activities and support. However, this finding needs to be interpreted cautiously given that only 175 service users had Christo scores recorded for both baseline and follow-up. Although the total number of discharges during the analysis period was 1,028, a proportion of these will be service users who did not complete their care plan and therefore had their case closed. It was not possible therefore to determine from the database the number of service users who completed their care plan and had their case reviewed and therefore should, in theory, have had a follow-up Christo score.

6.4 Key processes

In considering the successful outcomes for the Community Alcohol Service, it is important to highlight the processes, revealed predominantly through qualitative

interviews, which appear to have played a role in effective service delivery. However, it should be noted that those who participated in the qualitative interviews – service users and staff – were recruited as key informants rather than as representative of any group. In particular, it was not possible to speak to service users whose contact with ADS was limited in that they did not complete their care plan.

Those service users who were interviewed expressed positive views about their experiences with ADS as well as gratitude to ADS workers. The flexibility and consistency of care and support was evidenced in service users' descriptions of their experiences of the service. Their responses conveyed a view of a service which combined clear ground rules for engagement, with a degree of flexibility and informality. Service users spoke of the respect and trust they experienced, which they thought contributed to their willingness to engage and remain involved with the service. All interviewees identified a commitment to an individualised approach to assessing need and care planning as central to achieving positive outcomes with service users. Feedback from external agency staff attributed the quality of ADS assessments to their accurate identification of often complex needs.

Models of Care for Alcohol Misusers guidance (DH, 2006a) stresses the importance of aftercare in maintaining treatment gains. Feedback from service users regarding the impact of aftercare support and relapse prevention training was positive. Indeed, this emerged as an issue of primary importance to service users in identifying instrumental factors in remaining abstinent or working towards abstinence. The impact of service engagement on improvements in mental well-being also emerged as a key issue for service users. Again, the role of support and aftercare groups in promoting feelings of self-worth and confidence was consistently expressed. Findings suggest that aftercare support for service users plays a primary role in securing success. However, reference to the Service Level Agreement for the Community Alcohol Service indicates that provision of aftercare and support services was not included as an element of service delivery in the final service specification (Warrington PCT, 2006, p.13).

Government guidance cites cross-agency and cross-departmental communication as central to the development and delivery of programmes to develop alcohol misuse interventions (DH, 2005a). On a strategic level it would appear that ADS has made progress in developing joint working practices with agencies such as mental health and the police and these agencies expressed their satisfaction and support for the approach to joint working used by ADS.

6.5 Issues for consideration

Broadening the base of treatment for hazardous and harmful drinkers is a key aim of the *Alcohol Harm Reduction Strategy for England* (Prime Minister's Strategy Unit, 2004). In acknowledging the public health impact of those drinking at pre-dependent levels, approaches to secure the participation of all Tier 1 and 2 agencies in initiatives to address the needs of their hazardous and harmful service users is key to local alcohol strategies (DH, 2006a). The increase in comprehensive assessments taking place in primary care settings would indicate that these are hazardous or harmful drinkers, rather than dependent drinkers for whom referral would be made to Tier 3 Centre-based services. One in five patients presenting to primary care are likely to be 'excessive' drinkers, and, based on an average GP list size, each GP would see 364 'excessive' drinkers in a twelve month period (Heather & Kaner, 2002). A main finding of the ANARP report is the extremely low levels of formal identification, treatment and referral of patients with alcohol use disorders by GPs (DH, 2005b). Evidence from this report indicates that, at a local level, this continues to be the case. How to engage primary care remains a key challenge for both ADS and Warrington's Alcohol Harm Reduction Strategy Partnership.

National Treatment Agency targets for waiting times for substance misuse services are set for 2007 at 83% accessing treatment within three weeks. Statistics produced for the London Alcohol Statistics Project (2005) quoted waiting times of, on average, five weeks for accessing alcohol services (London Drug and Alcohol Network, 2005). Response times in this evaluation show that 98% of ADS service users were assessed within three weeks of referral; this compares favourably with national performance targets. Figures also show 87% of individuals accessing treatment within three weeks of assessment and 78% within two weeks. However, it should be noted that data recording and entry regarding offers of referral and interventions and actual take up of these appointments is incomplete. Qualitative interviews with all stakeholder groups generated feedback citing waiting times of less than a week, sometimes two to three days. This could suggest that here, as in other areas where data recording appears incomplete, inadequate recording has meant that performance has been under-reported.

At 48%, the average DNA rate for comprehensive assessments is high, although there is no relevant comparative data. ADS staff use a localised system for offering appointments whereby nine rather than seven appointment slots are scheduled for each project worker. The aim of this is to ensure that, in view of the likelihood of a

certain number of individuals not attending, the project worker's time remains fully allocated. It may be timely to consider strategies for lowering DNA rates. Equally, in view of the potential impact of repeat referrals and discharges on service demand, it may also be timely to review current processes and procedures for opening and closing of cases.

The ADS service manager reported that referral rates for community detoxification had been lower than anticipated and this was partly attributed to continued prescribing practices amongst several GPs. Thus, the community detoxification nurse has had responsibility for conducting initial assessments and this is thought to have contributed to the capacity of the service to respond rapidly to referrals. Again the implications of an increase in referrals from GPs regarding dependent drinkers suitable for home detoxification would need to be considered with regard to the capacity of the service to maintain current referral response times.

Although the development of relationships with primary care and other Tier 1 and 2 agencies is a strategic objective for the service, a point for consideration would be the Service's capacity, if referrals increase, to continue to deliver a timely response to increased demand. One and a half primary care-based worker posts currently provide three hour surgery 'slots' for hazardous and harmful drinkers in 11 out of Warrington's 29 GP surgeries.

Feedback from all external agency staff identified a need for alcohol outreach work in order to meet the needs of women and more vulnerable groups. Again, a strategy for delivering services for harmful and hazardous drinkers, away from the Centre, could involve the training of staff within appropriate agencies. In acknowledging the important role of aftercare support groups it would appear that, for dependent drinkers, accessing Centre-based activities is key to successful outcomes. However, feedback from mental health workers shows that for some more vulnerable dependent drinkers a one-to-one home-based approach to delivering support is the only option. The collaborative work between mental health and ADS might identify manageable solutions to addressing the needs of high risk service users.

6.6 Implications for future strategy and practice

This evaluation has identified a number of implications for local policy and practice. These factors are likely to support the Service's progress towards, and achievement of, its aims and objectives.

Data collection and management

- Prioritise the appointment of a database provider.
- Review the adequacy of current procedures regarding the collection and management of monitoring data to meet the reporting requirements identified during Stage Two of this evaluation (see Appendix 8).
- Ensure that case reviews include the recording of Christo scores and self-reported abstinence routinely and consistently and that this data is transferred to the database.
- Improve electronic record keeping in order to generate accurate denominators for key groups, such as 'discharged due to completion of care plan' and 'discharged due to drop out'.

Joint working

- Continue the focus on realising the placement of alcohol project workers in all Warrington's GP practices, or a venue in their locality, to address the issue of hazardous and harmful alcohol use amongst Warrington's population.
- Develop strategy, with the support of the Primary Care Trust, to broaden the base of identification and treatment of hazardous and harmful drinkers.
- Intensify efforts to promote knowledge and awareness of alcohol treatment issues amongst Tier 1 and 2 organisations and agencies. For example, to improve rates of access to the community detoxification service.

Service capacity

- Review the capacity of ADS resources, both central and local, to meet the monitoring and evaluation needs of the Warrington Community Alcohol Service.
- Consider the capacity of the current service to respond to the projected increase in referrals for treatment, in the event that ADS is able to increase its profile in GP practices.

Service processes

- Preserve those service processes identified in this evaluation that are most likely to lead to the positive engagement of those referred for alcohol misuse: for example, aftercare support and response rates.
- Review the strategy for monitoring and addressing DNA rates.
- Consider the management of repeat referrals within the context of the appropriateness of re-engaging service users following relapse.

References

- Alcohol and Drugs Service. (2005). *Tender proposal for Warrington Community Alcohol Service*. Alcohol and Drugs Service.
- Association of Public Health Observatories. (2007). *Indications of public health in the English regions*. York: Association of Public Health Observatories.
- Christo Research Systems. (2000). Christo Inventory for Substance Misuse Services. Retrieved 29th March 2007 from www.users.breathe.com/drgeorgechristo
- Department of Health. (2004). *Choosing health: Making healthy choices easier*. London: Department of Health.
- Department of Health. (2005a). *Alcohol Misuse Interventions: Guidance on developing a local programme of improvement*. London: National Treatment Agency for Substance Misuse.
- Department of Health. (2005b). *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England*. London: Department of Health.
- Department of Health. (2006a). *Models of care for alcohol misusers (MOCAM)*. London: National Treatment Agency for Substance Misuse.
- Department of Health. (2006b). *Review of the effectiveness of treatment for alcohol problems*. London: National Treatment Agency for Substance Misuse.
- Department of Health. (2007). *Safe. Sensible. Social: The next steps in the National Alcohol Strategy*. London: HM Government.
- Heather, N., & Kaner, J. (2002). Brief interventions against excessive alcohol consumption. In Warrell, D.A., Cox, T.M., Firth, J.D., & Benz, E.J.(Eds), *Oxford Textbook of Medicine (4th Edition)*. Oxford Medical Publications.
- Information Centre for Health and Social Care. (2006). Hospital episode statistics. Retrieved July 27th 2007 from www.ic.nhs.uk
- London Drug and Alcohol Network. (2005). *London Alcohol Statistics Project*. London: Kings Fund.
- Mann F., & Thurston M. (2007). *Implementation of a monitoring and evaluation strategy for the Community Alcohol Service in Warrington*. University of Chester.
- North West Public Health Observatory. (2006). *Local Alcohol Profiles for England–North West*. Retrieved 12th April 2006 from www.nwph.net/alcohol
- Office for National Statistics. (2006). *Alcohol-related deaths in the United Kingdom 1991-2005*. Retrieved June 14th 2007 from www.statistics.gov.uk
- Office for National Statistics. (2007). *Neighbourhood statistics – Warrington (Local Authority)*. Retrieved July 26th 2007 from www.neighbourhood.statistics.gov.uk
- Prime Minister's Strategy Unit. (2004). *Alcohol harm reduction strategy for England*. London: Cabinet Office.

Prochaska, J.O., Diclemente, C.C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviours. *American Psychologist*, 47,1102-1114.

Warrington Primary Care Trust. (2005). *Specification for a structured community-based alcohol service*. Warrington Primary Care Trust.

Warrington Primary Care Trust. (2006). *Agreement relating to the provision of a structured community-based alcohol service*. Warrington Primary Care Trust.

Warrington Primary Care Trust. (2007a). *A five year strategy for improving health in Warrington*. Warrington Primary Care Trust. Retrieved July 26th 2007 from www.warrington-pct.nhs.uk

Warrington Primary Care Trust (2007b). LPSA 2 Forecast monitoring document. Warrington PCT.

Warrington Local Strategic Partnership. (2005). *Warrington harm reduction strategy 2006 – 2009*. Warrington Local Strategic Partnership.

Appendix 1

Key performance indicators

KPI No.	Key Performance Measure	Whom
1.	Alcohol consumption (units) prior to intervention	Tier 1 Services
2.	Number of alcohol related admissions to A&E	A&E
3.	Number of alcohol related admissions to inpatient beds	A&E
4.	Number of referrals into service and source, age, gender, ethnicity and location	Alcohol Team
5.	Number of referrals who have had a previous completed episode of treatment	Alcohol Team
6.	Average and longest waiting time for assessment	Alcohol Team
7.	Average and longest waiting time for admission to the service pre initial assessment and following initial assessment	Alcohol Team
8.	Number of people waiting for each modality of treatment at month end	Alcohol Team
9.	Number of people receiving brief advice at month end	Tier 1 Services
10.	Number of people receiving Brief Interventions at month end	Alcohol Team
11.	Number of people receiving community detox at month end	Alcohol Team
12.	Numbers of people receiving support from Alcohol Support Workers at month end	Alcohol Team
13.	Numbers of people receiving tertiary inpatient detox at month end	Alcohol Team

Appendix 2

Christo screening tool

COMPREHENSIVE ASSESSMENT

Data Collection

CHRISTO

To be completed by Project Worker after the session

0 – No Problem, 1 – Moderate Problem, 2 – Severe Problem

SOCIAL FUNCTIONING

- 0... e.g. client has a stable place to live and supportive friends or relatives who are drug / alcohol free. ☐
- 1... e.g. client's living situation may not be stable.... or they may associate with drug users / heavy drinkers... (Tick one)
- 2... e.g. client's living situation not stable and they claim to have no friends or their friends are drug users / heavy drinkers

GENERAL HEALTH

- 0... e.g. client has reported no significant health problems ☐
- 1... moderate health problems (e.g. teeth / sleep problems, occasional stomach pain, collapsed vein, asymptomatic hep B / C / HIV)
- 2... major health problems (e.g. extreme weight loss, jaundice, abscesses / infections, coughing up blood, fever, overdose, blackouts seizures, significant memory loss, neurological damage, HIV symptoms)

SEXUAL/INJECTING RISK BEHAVIOUR

- 0... e.g. client claims not to inject, or have unsafe sex (except in monogamous relationship with longstanding partner/spouse). ☐
- 1... e.g. may admit to occasional 'unsafe' sexual encounters, or suspected to be injecting but denies sharing injecting equipment.
- 2... e.g. client may admit too regular 'unsafe' sexual encounters, or has recently been injecting and sharing injecting equipment.

PSYCHOLOGICAL

- 0... e.g. client appears well adjusted and relatively satisfied with the way their life is going. ☐
- 1... e.g. client may have low self-esteem, generally anxiety, poor sleep, may be unhappy or dissatisfied with their lot.
- 2... client has a neurotic disorder e.g. panic attacks, phobias, OCD, bulimia, recently attempted or seriously considered suicide, self-harm, overdose or may be clinically depressed. Or client may have psychotic disorders, paranoia (e.g. everybody is plotting against them). Deluded beliefs or hallucinations (e.g. hearing voices)

OCCUPATION

- 0... client in full time occupation e.g. homemaker, parent, employed or student ☐
- 1... e.g. client has some part time parenting, occupation or voluntary work.
- 2... e.g. client is largely unoccupied with any socially acceptable pastime.

CRIMINAL INVOLVEMENT

- 0... e.g. no criminal involvement (apart from possible possession of illicit drugs for personal use). ☐
- 1... e.g. client suspected of irregular criminal involvement, perhaps petty fraud, petty theft, drunk driving, small-scale dealing.
- 2... e.g. suspected of regular criminal involvement, or breaking and entering, car theft, robbery, violence, assault.

DRUG/ALCOHOL USE

- 0... e.g. no recent drug/alcohol use ☐
- 1... e.g. client suspected of periodic drug/alcohol use, or else may be socially using drugs that are not considered a problem, or may be on prescribed drugs but not supplementing from other sources.
- 2... e.g. client suspected of bingeing or regular drug/alcohol use.

ONGOING SUPPORT

- 0... e.g. regular attendance of AA/NA, drug free drop in centre, day centre, counseling or treatment aftercare. ☐
- 1... e.g. patchy attendance i.e. less than once a week contact with at least one of the above.
- 2... e.g. client not known to be using any type of structured support.

COMPLIANCE

- 0... e.g. attends all appointments and meetings on time, follows suggestions, or complies with treatment requirements. ☐
- 1... e.g. not very reliable, or may have been reported as having an "attitude" problem or other difficulty with staff.
- 2... e.g. Chaotic, may have left treatment against staff advice or been ejected for non-compliance e.g. drug use, attitude problem.

WORKING REALTIONSHIP

- 0... Relatively easy going e.g. interviews easily, not time consuming or stressful to work with. ☐
- 1... Moderately challenging e.g. a bit demanding or time consuming, but not excessively so.
- 2... Quite challenging e.g. very demanding, hard work, time consuming, emotionally draining or stressful to see.

CISS TOTAL SCORE

(Admin - Enter the Christo Score on % talkback field on main substance tab)

Appendix 3

Service user interview schedule

WARRINGTON COMMUNITY ALCOHOL SERVICE

INTERVIEW SCHEDULE - SERVICE USERS

Introduction to ADS.

First I would just like to find out a bit more from you about how you first came in contact with ADS.

1. Were you referred by another organisation?
If so, which/who?
If not, how did you hear about ADS?
2. What was your first impression when you came here? Was it what you had expected?

Previous agency involvement

I'd like to know a bit more about any experience you have of alcohol services before your involvement with ADS.

3. Had you had any experience of alcohol services before coming along to ADS?
If so, what did you think?
4. Had you ever tried to seek help before?
If so, could you tell me a little bit about that experience.

Experience of ADS services

Now I'd like to find out a little bit more about what you think of the support that ADS offers?

6. Do you think they offer the right amount of support?
7. Do you think they offer the right type of support?
8. Do you feel you can see someone as and when you need to?
9. Do you feel you have enough say in choosing and reviewing your care plan?
Prompt: Deciding what groups or treatment are right for you, deciding on when you are ready to join different activities.
10. What effect do you feel your involvement with ADS had on:
a) your drinking?
b) your physical and mental well-being?
b) your day to day life?

11. What about your family and close friends, do you feel they have benefited from your engagement with ADS?

Suggestions and comments.

I would be interested to hear what suggestions you might have for improving or changing the services which ADS offers.

10. Is there anything about the service that you feel could or should be done differently?
11. One of ADS' aims is to reach as many people who may need their support as possible. How do you think this could be done?

Thank you for sharing your time and your views with me.

Appendix 4

ADS staff focus group schedule

WARRINGTON COMMUNITY ALCOHOL SERVICE

ADS STAFF FOCUS GROUP SCHEDULE

Introduction: Reference to participant information sheet, audio taping, confidentiality.

1. What do you place most importance on when seeking to meet the needs of your clients?
2. What gets in the way of your ability to respond to clients needs both practically and from a resource point of view.
 - a) within the organisation
 - b) externally
3. Thinking of the clients themselves, what do you think for them are the main barriers to achieving their goals/targets?
4. What are the issues for agencies and workers aiming to address the needs of alcohol misusers and their 'concerned others'?
5. Thinking about your day to day workload, how much of what you do is pre-planned and how much is in response to presenting need?
Prompt: What's the difference between the job on paper and the job in practice?
6. Which external agencies do you feel are best engaged with meeting the needs of the alcohol misusing population of Warrington?
Why?
7. Are there any agencies/organisation/professions which you feel could more fully engage with Warrington's alcohol strategy and the work of ADS?
Why?
8. What, internal or external, strategic or operational changes would make your job easier?
9. What would improve the ability of your clients to access and engage with services aimed at addressing their alcohol misuse?

Appendix 5

External agency staff interview schedule

WARRINGTON COMMUNITY ALCOHOL SERVICE

INTERVIEW SCHEDULE – EXTERNAL AGENCY STAFF

1. How has the introduction of a Community Alcohol Service impacted upon the work of your agency?
2. Prior to the launch of ADS what would have been your agency's approach to meeting the needs of its alcohol misusing service users?
3. Part of the ADS remit with regard to alcohol misuse has been to develop referral pathways and improve co-ordination between agencies. Do you think they have succeeded in this?
If so, how?
If not, why?
4. Have you referred any service users to ADS?
If so, i) with what frequency and; ii) how straightforward is the process?;
If not, why not?
5. Are you aware of the outcomes for any of your clients/service users following their involvement with ADS?
6. Do you feel that the current level of service provision for Warrington's alcohol misusing population is adequate/appropriate?
If not, could you identify the shortfalls/gaps?
7. In your experience, what do you feel are the main issues to be considered in providing services to address the needs of Warrington's alcohol misusing population?

Thank you for your time.

Appendix 6

Participant letter of invitation

Date as postmark

Alcohol and Drugs Services (ADS)

We are writing to invite you to take part in a research study. The University of Chester has been asked by Warrington PCT to carry out an evaluation of the service offered by ADS in Warrington. This means that we need to find out more about how the service is working and how it might have affected the people who have received it. Your views and experiences are therefore important to us if we are to gather a clear picture of the work that ADS does and how successful it has been in providing people with the help and support they need.

We would be grateful if you would be willing to take part in an interview to find out your views and experiences of ADS. The interview should take no more than 45 minutes and would take place at the ADS Centre in Museum Street. Please be assured that all information you share during the interview will be kept confidential by the research team. No names or details that could identify you will be used in any reports written about this study.

With this letter, you will be given an information sheet which tells you a bit more about what we are doing and why we are doing it. We would be grateful if you would let your case worker know, within two weeks, if you would be willing to take part in an interview. Your case worker will then arrange a time and date for us to meet which is convenient to you. With the letter is a consent slip which, if you do agree to take part, you should sign and bring along to the interview.

You do not have to take part in this study and not doing so will not affect the service you receive from ADS in any way. If you do not want to take part you do not have to give a reason.

Thank you for your help.

Yours sincerely

Frances Mann
Senior Researcher
Centre for Public Health Research

Appendix 7

Participant information sheet and consent form

Participant Information Sheet

Information on the evaluation of Warrington District Hospital's Alcohol Brief Intervention service.

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why this is being done and what it means to you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the study for?

We want to look at the Community Alcohol Service offered in Warrington by the Alcohol and Drugs Services (ADS) organisation. We want to see how well the service is working in meeting the needs of people in Warrington. Through asking for your views we aim to find out more about how the service works and how it might have affected the people who have received it.

Why have I been chosen?

You have been chosen because you are currently using ADS' services.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you are still free to change your mind either before or during the interview session. We will not ask you for your reasons if you do. ***Deciding not to take part won't in any way affect any care or treatment you receive.***

What will happen to me if I take part?

We would like to talk to you about your views and experiences of the service you have received from ADS and any effect which you feel your involvement has had on you. All information you share with us will be kept confidential by the research team. No names or details that could identify you will be used in any reports written about this study.

What will happen to the results of the study?

A report will be written which will talk about the views and experiences of the people who have been involved with the Community Alcohol Service offered by ADS. No names or details that could identify you will be used in this, or any other report. All information collected during this work will be kept confidential and only be used for this study.

What are the possible disadvantages to taking part in this study?

We do not think there are any disadvantages to your taking part in this study.

What are the benefits to taking part?

You will be sharing your views and this might help both ADS and Warrington Primary Care Trust (Warrington PCT) to think about what alcohol services they need to provide for local people.

Who is organising and funding the study?

The study is being funded by Warrington PCT. A senior researcher from the Centre for Public Health Research here at the University of Chester will be organising the study.

Complaints procedure

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact Professor Sarah Andrew, University of Chester, Parkgate Road, Chester CH1 4BJ, Tel: 01244 513055.

Who may I contact for further information?

If you require any further information, or would like to talk over anything, please contact Frances Mann at the University of Chester on 01244 512059.
email – frances.mann@chester.ac.uk

Thank you

Please read the above information and sign below if you consent to participate in this research exercise.

Please tick as appropriate

I agree to participate in the interview ☐

I agree to the interview being audio taped ☐

Name:..... **Date:**

Signature:

Appendix 8

Monthly activity report template

**ADS ACTIVITY INDICATOR
MONTHLY REPORT OUTLINE**

	Month	Month	Month
	No.	No.	No.
Total			
Male			
Female			
18-29			
30-49			
50-69			
70+			
Warrington resident			
Other			
A&E			
GP			
Mental health services			
Probation			
Social services			
Self			
Other			
Ethnicity			
White British			
White Irish			
White other			
Bangladesh			
Pakistan			
Indian			
Asian other			
Black African			
Black Caribbean			
Black other			
Other			
Previous experience of treatment for alcohol misuse			
RECORDED CONCERN			
Mental health			
Physical health			
Childcare responsibilities			
Accommodation			
INITIAL ASSESSMENTS			
ADS setting			
Primary care setting			
COMPREHENSIVE ASSESSMENTS			
Completed			
DNA			

ACTIVE CLIENTS			
Total			
Male			
Female			
18-29			
30-49			
50-69			
70+			
TREATMENT MODALITY			
Counselling: active			
Counselling: DNA			
Counselling: awaiting			
Group work: active			
Group work: DNA			
Group work: awaiting			
Alternative therapy: active			
Alternative therapy: DNA			
Alternative therapy: awaiting			
Home Detox: active			
Home Detox: completed			
Home Detox: awaiting			
Inpatient Detox: active			
Inpatient Detox: completed			
Inpatient Detox: awaiting			
OUTCOMES – REVIEW & DISCHARGES			
Never active			
Alcohol abstinence			
Alcohol reduction			
No appropriate treatment			
Cessation of involvement- withdrawn			
Cessation of involvement- external factors			
Referred to other agency			
Deceased			
RESPONSE TIMES	No. Days	No. Days	No. Days
From: date of referral			
To: date of initial / comprehensive assess.			
Mean			
Range (low-high)			
From: date of initial/comp. assess To: date of intervention commencement			
Mean			
Range (low-high)			